Characteristics of Highly Resilient Therapists

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Jian-Ming Hou

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Abstract

Ten highly resilient therapists from diverse mental health professions were recruited to participate in this qualitative study that aimed to explore characteristics that sustain therapists' resilience. Participants were selected through two phases of sample screening: peer nomination and two quantitative scales. Of the 10 participants, 9 were female and 1 was male; age ranged from 41 to 70 years old. Nine participants identified as White and 1 identified as Native American. Seven participants were doctoral-level licensed psychologists, 2 participants were master-level licensed marriage and family therapists, and 1 was a master-level licensed social worker. One practiced at a college counseling center, 5 were in private practice, 2 were in community clinics, and 1 practiced in both a community clinic and a private practice. Data were collected through semi-structured, in-person interviews with a focus on three research questions: "What are the characteristics of highly resilient therapists?" "Is there an innate or inner force that drives resilient therapists to grow through professional risks?" and "How can one more accurately define the term *Resilient Therapists?*" Grounded Theory served as the framework for data analysis. The research findings yielded four categories, 11 subcategories, and related word/phrase characteristics. Four major categories were (A) Drawn to Strong Interpersonal Relationships, (B) Possess a Core Values and Beliefs Framework, (C) Actively Engage with the Core Self, and (D) Desire to Learn and Grow. A strong web of vibrant connectedness was identified as the central characteristic that interlinked with each category. The central characteristic of *connectedness* for therapist resilience has not identified as having a vital role in previous studies. The final result was

a definition of the Highly Resilient Therapist. Recommendations and implications for future studies and practice were also provided.

Table of Contents

List of Tables

List of Figures

Chapter One

Introduction

For the unique work of mental health practitioners, every professional relationship begins with a hello and then has a goodbye. The depth and intensity of professional attachment and detachment during a short time from one client to another can make each greeting and termination emotionally depleting. For therapists and counselors, to ensure a successful and professional alliance, they must use their caring side—"the underside of the turtle" (Skovholt, 2005, p. 88) instead of the hard shell side. The use of "the underside of the turtle," in other words, also means that therapists must reveal their vulnerable side in order to facilitate a successful therapeutic relationship. However, to reveal the vulnerable side also means exposing to potential risks. Therefore, it is not surprising that vulnerability, risk factors, and negative effects of counseling work have been prevalent topics in both quantitative and qualitative studies in the field of counseling and psychology.

In the field of psychology, Emily Werner's Kauai Longitudinal Study (1982) and Norman Garmezy's Project Competence (1991) are perhaps the most well-known longitudinal research studies of children at risk in the United States. With an intention to search for risk factors and negative effects of a vulnerable upbringing among identified at-risk children, both research teams noticed participants, originally identified as vulnerable, who continued to manifest high-levels of adaptation and competence despite high-risk circumstances. Coincidentally, both research projects decided to switch research directions from a pathological-oriented to a resilient-oriented focus, and their redirected research helped initiate the burgeoning studies on resilience across different

psychology-related fields. For example, here is a quote describing this shift: “Too often we focus on disorders, psychopathology, dysfunction, and problems. We must balance these negative elements with a focus on altruism, compassion, resilience, success, and thriving” (Radey & Figley, 2007, p. 208).

The shift is slowly occurring with practitioners too. To date, despite a rich number of empirical studies focusing on the risk factors and negative effects of counseling work, little research has investigated the resilient side of therapists or attempted to explore what it means to be a resilient therapist. Given the switching focus from children at risk to resilience children studies, research on therapists’ resilience seems more plausible. Thus, the aim of this present study is to address the resilient side of therapists. In particular, this present study intends to explore characteristics that sustain therapists’ resilience and provide an in-depth definition of highly resilient therapists. For the sake of clarity, the term “therapist”, “counselor”, “mental health practitioner”, and “psychotherapist” are used interchangeably throughout the literature review.

Defining Resilience

The term *resilience* was first used by Thomas Tredgold (as cited in McAslan, 2010) in order to describe timber that had the capacity to both withstand breaking and acclimate to extreme load under abrupt changes. The study of resilience has now expanded and become prevalent in diverse disciplines. For example, in the areas of physics and engineering, resilience may refer to the strength of materials to withstand damage under extreme force. In the field of business, resilience may refer to the capacity of an organization to recover from and maintain operations even after severe interruption. Research on resilience and coping in the field of psychology began in the 1970s’ (Kitano

& Lewis, 2005) and has been expanded to psychopathology, developmental psychology, clinical social work, and related fields. Concepts used to describe qualities similar to *resilience* include protective factors (Cohen & Lazarus,1973), stress resistance (Garmezy, 1985), psychological hardiness (Kobasa, Maddi, & Kahn, 1982), self-efficacy (Bandura, 1977), and, strengths, virtues, and characteristics identified in the field of positive psychology (Seligman & Csikszentmihalyi, 2000).

In the diverse discipline of psychology, the terms "resilience," "resiliency," and "psychological resilience" are seemly interchangeable and used to describe human mental functions and behaviors, with "resilient" being the adjective. However, the definition of resilience has varied. Especially in at-risk children and adolescent studies, the major dichotomy of definitions appears to associate with "what constructs resilience?" Although resilience has long been viewed as a personal trait or attribute, some also argued that resilience is an ongoing dynamic process (Tedeschi & Kilmer, 2005). Given dissimilarity or ambiguity of the concept of resilience, Kaplan (2005) suggested that "any consensus that exists regarding the nature of resilience rests upon the idea of achievement of positively (or the avoidance of negatively) valued outcomes in circumstances where adverse outcomes would normally be expected (p. 39)." Lightsey (2006) also proposed:

> Operationalized, psychological resilience should, of course, be reliable and valid—that is, internally consistent, reasonably, consistent over time, and separable from other important constructs including skills, or competencies (e.g., problem-solving and coping skills), environmental supports (e.g., income, job, and social support), and stress (p. 100).

As discussed earlier, Emily Werner's Kauai Longitudinal Study, began in 1955,

and Norman Garmezy's, Minnesota Risk Research Project (also called Project Competence), began in 1971, are perhaps the most well-known resilience research studies of children at risk in American psychology. However, only later was the term resilience used in these research studies. As a child psychologist, Werner and her colleague (Werner & Smith, 1992) defined resilience along with the concept of protective factors:

> Resilience and protective factors are the positive counterparts to both vulnerability, which denotes an individual's susceptibility to a disorder, and risk factors which are biological or psychosocial hazards that increase the likelihood of a negative developmental outcome in a group of people (p. 3).

Werner and Smith (1992) also referred to resilience as an innate "self-righting mechanism" (p. 202) within every individual.

Garmezy (1993), a clinical psychology professor, defined resilience as "the presence of any or many of these self-same risk factors, but the accompanying adaptive outcomes are now presumed to be a function of evident, or unidentified, positive elements within the individual and external environments that serve as a protective function" (p. 379). As a psychological concept, "psychological resilience is concerned with behavioral adaptation, usually defined in terms of internal states of well-being or effective functioning in the environment or both" (Masten, Best, & Garmezy, 1990, p. 426). Two functioning elements are associated with the nature and content of resilience as follows:

> (a) a growing appreciation of a latent construct that can be termed adaptability and (b) an awareness of the omnipresent qualities of various types of competencies that appear to serve as practice factors despite the presence of risk

reflected in deviant families, distorted rearing practices, family poverty, and the stress of disadvantaged ecologies" (Garmezy, 1993, p. 378).

Rutter (1987), a British psychiatrist, proposed that resilience as a whole is "concerned with individual variations in response to risk. Some people succumb to stress and adversity whereas others overcome life hazards" (p. 317). For Flach (1988), resilience was "the psychological and biological strengths required to successfully master change" (p. xi). Flach proposed that it is through the "Law of Disruption and Reintegration" (Flach, 1988; Flach, 1997) that one can attain resilient qualities. Based on studies on trauma survivors, Hernandez, Gansei, and Engstrom, (2007) referred to resilience as "the way in which trauma survivors access adaptive processes and coping mechanisms to survive and even thrive in the face of adversity" (p. 229).

Luthar, Cicchetti, and Becker (2000) synthesized the leading investigators' work on resilience and defined resilience as "a dynamic process encompassing positive adaptation within the context of significant adversity"(p. 543). Two conditions of adversity had to be met: "(1) exposure to significant threat or severe adversity, and (2) the achievement of positive adaptation despite major assaults on the developmental process (p. 543)."

Defining "Resilient Therapist"

For social workers, Collins' (2007) definition of resilience is a close one for defining resilient therapists in the mental health professions. Collins referred to resilience as "an adaptive state and personality trait evident in many people, including social workers, but it is influenced by many variables, such as culture" (2007, p. 255). Collins (2007) also proposed two significant characteristics: "optimism" and "hope" (p. 263) for

social workers in dealing with demands in their work. For therapists in the mental health professions, however, there are few empirical studies that used the term "resilience" to describe therapists' well-being, what it means to be a resilient therapist, and what characteristics are essential for therapists to remain resilience. For example, in his dissertation, David (2012) investigated the relation between Compassion Fatigue and the level of resilience among therapists. Through his quantitative study, participants' burnout, compassion satisfaction, and resilience were examined with data collected Professional Quality of Life Scale Version 5 (ProQOL-5; Stamm, 2009), and Connor-Davison Resilience Scale (CD-RISC; Connor & Davison, 2003). In David's findings, therapists' compassion fatigue, burnout, and compassion satisfaction together were significantly related to their level of resilience. However, gender, years of clinical practice, educational level, and the combination of years of clinical practice and numbers of clients treated were found to have no significant relationship to therapists' level of resilience.

In a dissertation research study conducted by Lidderdale (2009), she explored resilience in the lives of white, midlife lesbian psychologists in clinical practice. She adopted Luthar's (2003) definition of resilience for her study: "manifestation of positive adaptation despite significant life adversity" (as cited in Lidderdale, 2009, p. 13). Through her phenomenological investigation, several inner resources were found to be useful for lesbian psychologists' resilience responses, such as "(a) passion, (b) an inner sense, (c) value of an inner life as important, and (d) value of authenticity combined with a sense of justice" (p. 182). These inner resources seemed to inform an understanding of therapists' resilience. On the other hand, due to the homogeneity of her participants' gender, sexual orientation, and a focus on resilience among participants' lived

experiences, rather than resilience in the professional world, Lidderdale's findings may not be directly applicable to this present study.

In a dissertation study, Mullenbach (2000) investigated both risk and protective factors associated with emotional wellness and professional resiliency among peer-nominated expert mental health practitioners. In her study, professional resiliency was defined as "a dynamic pattern that, over time, is marked by positive adaptation to an array of normal stress factors as well as other non-normative incidents or experiences that are acute in nature" (Mullenbach, 2000, p. 11). Through her qualitative analysis, five resiliency-oriented categories about the expert mental health practitioners were found: (*1) Professional Stressors, (2) Emergence of the Expert Practitioner, (3) Creating a Positive Work Structure, (4) Protective Factors,* and *(5) Nurturing Self through Solitude and Relationships*. To explore what contributed to master therapists' emotional wellness and professional resiliency, this study centered its focus on identifying stressors and self-care behaviors. However, with a sample group of master therapists, rather than resilient therapists, findings of this research is limited in its applicability to the search for characteristics of highly resilient therapists.

Through the pathological lens, vulnerability, risks, maladaptation, disruptions, dysfunction, and professional depletion of therapists and counselors have long been studied. Risk-factor oriented studies have investigated negative effects caused by counseling work, such as vicarious trauma (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995), secondary traumatic stress, compassion fatigue (Figley, 1995, 2002; Stamm, 2010), and professional burnout (Maslach & Leiter, 1997). The first three terms are often described as overlapping in the literature. Several psychometric measurements

were developed to assess the deficit outcomes of counseling work, such as Maslach Burnout Inventory (MBI; Maslach, Jackson & Leiter, 1996), Secondary Traumatic Stress Scale (STSS; Bride et al., 2004), and Compassion Fatigue Self Test for Helpers (CFST; Figley, 1995).

Researchers have identified several personal risk factors of therapists that may contribute to negative effects of counseling work, such as counselors' childhood abuse history, age, gender, and years of clinical experiences (Ghahramanlou & Brodbeck, 2000; Kassam-Adams, 1995; VanDeusen & Way, 2006; Way, VanDeusen, & Cottrell, 2007), educational level (Baird & Jekins, 2003), social anxiety, escape coping, and low confidence (Liter & Harvie, 1996), an unrealistic mindset about professional impairment (Barnett, Baker, Elman, & Schoener, 2007), and lack of knowledge about self-care (Sapienza & Bugental, 2000). Others have discussed risk factors caused at the organizational level, such as caseload, work hours, inadequate clinical supervision, and inadequate social support (Follette, Polusny, & Milbeck, 1994; Kassam-Addams, 1995; Liter & Harvie, 1996; Pearlman & Mac Ian, 1993; Rosenberg & Pace, 2006). In fact, because of the large number of published studies concerning professional burnout, it is not surprising to find several systematic literature reviews aiming to summarize and synthesize common risk factors that contribute to professional burnout (e.g. Liter & Harvie, 1996; Maslach & Leiter, 2008).

Although studies pertaining to risk factors may not be based on the resilient lens, the recognition of risk factors, adversity, and challenges of counseling work can enrich our understanding of what resilient therapists have to cope with in their routine work and throughout their professional development.

Protective-factor oriented studies, on the other hand, are also closely related to our search for resilient therapists. Similar to Mullenbach's (2000) study that took a non-pathological perspective, a number of studies have looked into protective practices, adaptive coping mechanisms, or self-care strategies among therapists. For example, in Harrison and Westwood's (2009) qualitative study, they aimed to investigate protective practices that sustained and prevented therapists from vicarious traumatization. Participants recruited for this study were peer and organizationally nominated on the basis of educational level, years of professional experiences, and "self-identified as having managed well in this work" (p. 206). Also, participants had to have scored below average on the Burnout and Compassion Fatigue Subscales of the Pro-QOL that were below average. Thus, the combination of peer nomination and low score on the Pro-QOL were used to select the sample group for this study. After in-depth interviews and narrative analyses, Harrison and Westwood found nine patterns of protective practice to be beneficial for restoring balance in counseling work:

- Countering Isolation in Professional, Personal and Spiritual Domains of Life
- Developing Mindful Awareness: Integrated Practice of Spirituality
- Consciously Expanding Perspective To Embrace Complexity
- Active Optimism
- Holistic Self-Care
- Maintaining Clear Boundaries and Honoring Limits
- Exquisite Empathy
- Professional Satisfaction
- Creating Meaning

(Harrison & Westwood, 2006, p. 208-213)

It is important to note that studies related to adaptive coping mechanisms among therapists help our understanding of how resilient therapists can, or may, react in responding to risks and adversity in professional work. However, it is common that suggested coping mechanisms sometimes consists of advice given in the discussion, recommendation, application or conclusion sections at the end of risk-factor oriented research, rather than directly from studies on protective-factor oriented research, like Harrison and Westwood's (2009) study. Among current published literature, common coping and self-care strategies found to be beneficial for therapists include: physical and mental health promoting activities (e.g. sleeping, exercise, and diet), spiritual-related activities (e.g. exposing to nature, keeping journal, and meditating), and leisure activities (e.g. gardening, seeing movies, reading, and listening to music) (Schauben & Frazier, 1995); awareness of individual and organizational stress (Maslach & Leiter, 2008); awareness of individual and organizational stress (Figley, 2002b); outdoor activities and self-expression (Hesse, 2002); assurance of adequate nutrition, diet, sleep, exercise, and pleasurable hobbies (Pearlman, 1999); regular supervision (Sommer & Cox, 2005; Grosch & Olsen, 1994); realistic goals for caseload and client care, sufficient breaks and rest, positive and supportive personal and professional relationships (Maslach, 2003a, 2003b); professional development, continual education and training and spirituality (Trippany, Kress & Wilcoxon, 2004).

Furthermore, "master therapist" and "well/highly functioning therapist" seem to share similar constructs with the "resilient therapist." The master therapist studies began with Harrington's (1988) quantitative research of ABPP Board Certified American Psychologists. Later there were qualitative studies which began with Jennings' (Jenings,

1996) doctoral dissertation that aimed to explore the personal characteristics of ten master therapists. Mullenbach (2000) and Sullivan (2001) continued this research line in their dissertations, which attempted to probe deeper into what it means to be a master therapist. Thomas Skovholt was the dissertation advisor of these studies. Skovholt conducted a follow-up interview with these three researchers, Jennings, Mullenbach, and Sullivan, with an intention of refining the portrait of the highly functioning master therapist based on their research. They concluded four types of characteristics of highly functioning master therapists (Skovholt, Jennings, & Mullenbach, 2004) were identified across these dissertation studies—paradox characteristics, identifying characteristics, word characteristics, and central characteristics. Wisdom refined from these studies provided a scope for our understanding of resilient therapists.

Likewise, Coster and Schwebel (1997) also conducted a study exploring how therapists maintain well-functioning. In their study, well-functioning was defined as "the enduring quality in an individual's functioning over time and in the face of professional and personal stressors" (p. 5). Similar to Mullenbach's (2000) study, resource and actions for coping with impairment and sustaining well-functioning were the central focus of Coster and Schwebel's study. It is unknown whether or not any overlap exists between highly functioning master therapists and "resilient therapists." From the developmental perspective, however, if becoming a highly functioning master therapist is a desired process in a therapist's development, characteristics of highly/well-functioning master therapists could inform our understanding of resilient therapists.

Statement of the Problem

In many psychology-related fields, resilient-oriented studies have received

increasing attention and continue to grow, especially with regard to children and adolescent resilience. On the other hand, in the last two decades, the trend has shifted from pathology to strengths and positive psychology, although pathology is still the mainstream in the field of counseling psychology. Although knowing deficits and negative effects of counseling work on therapists increases our understanding of vulnerability, hazards, and adversity, as well as impairments that therapists may experience, the invulnerable and resilient sides of therapists are little known. Even though some existing research has attempted to take a non-pathological perspective and explore protective factors, protective practice, adaptive coping mechanism, or self-care strategies of therapists who are doing well, their main focus has centered on what therapists need to "do" or "how to react" in order to prevent vulnerability. Nevertheless, what characteristics a therapist needs to have or nurture in order to "be," "become," and "maintain" resilient remain unknown. Moreover, in most studies, therapists who are considered at risk are often those who work with abused or trauma-related clients (Benatar, 2000; Conner & Davidson, 2003; Follette et al., 1994; Sommer & Cox, 2005; VanDeusen & Cottrell, 2007; VanDeusen & Way, 2006). However, mental health professionals who work in general mental health settings (e.g. community clinics, college counseling centers, and private practice) and how they manifest invulnerability and resilience over years of clinical work has explored less. Also, studies of master therapists may help our understanding of resilient therapists, and it is very possible that characteristics of master therapists and resilient therapists may overlap. Or, conversely, the source or drive for becoming the "best of the best" may not be the same as for those who strive to maintain resilience. What sources drive a therapist to consistently "beat the

odds" and continue to remain resilience? What it means to "be" a resilient therapist? These questions remained unknown.

Purpose of the Study

From a resilience perspective—and moving beyond identifying risk factors, stressors, self-care strategies, or coping responses among therapists who are doing well—the first goal of this study is to explore characteristics of highly resilient therapists. The second goal of this study is to explore the whether there is a "force/energy" that drives resilient therapists to grow through professional challenges so as to remain resilient over years of practice. Based on years of a longitudinal study tracking high-risk children to their adulthood, Werner (1992) came to realize that the central component for resilient participants to feel confident, to cope, to succeed against the odds was "hope" (p. 265). Werner and Smith (1992) also said that resilience is an innate "self-righting mechanism" (p. 202) within every individual. Rutter (1987) also suggested scholars focus particular attention on "the mechanisms operating at key turning points in people's lives when a risk trajectory may be redirected onto a more adaptive path" (p. 329). Allying with Werner and Smith, and Rutter, Richardson (2002) also believes that "there is a force within everyone that drives them to seek self-actualization, altruism, wisdom, and harmony with a spiritual source of strength. The source is resilience" (p. 313). Following the line of the conceptual definition of resilience that Werner and Smith, Rutter, and Richardson offer, the second goal of this study is to explore the whether there is a separate "force/energy" that drives resilient therapists to grow through professional challenges so as to remain resilient over years of practice. Finally, with the first and second goals described above, this study will attempt to offer a broad and deep definition

of the characteristics of the highly resilient therapist.

Research Questions

The present study is focused on the following three questions for this qualitative investigation of highly resilient therapist:

1. What are the characteristics of highly resilient therapists?
2. Is there an innate or inner force that drives resilient therapists to grow through professional risks?
3. How can one more accurately define the term "resilient therapist"?

Definitions

Based on a critical literature review, in consultation with this primary researcher's adviser, as well as derived from a number of sources (Rønnestad & Skovholt, 2013; Richardson et al., 1990; Skovholt, 2001, 2005, 2012) the term "highly resilient therapist" in the present study refers to: While working as a therapist for many years, a highly resilient therapist is effective as a therapist with his/her clients and is able to be fully engaged with client after client. Over time, a highly resilient therapist is able to continually bounce back from discouraging and disruptive aspects of clinical work. The highly resilient therapist is also able to develop recurrent professional optimism and vitality, as well as experience ongoing professional growth."

Summary of the Chapters

In Chapter One, an introduction to the study is provided. In Chapter Two, two historical studies on resilience in the U.S. will be presented, followed with a review of theoretical frameworks for this study and a critical review of empirical studies related to highly resilient therapists. An overview of literature investigating risk factors, protective

factors, and constructs related to resilient therapists will also be offered. In Chapter Three, I will outline the methodology employed in this study. Descriptions of the sample selection, procedures, instruments, and data analysis will be provided. Next, the results of the data analysis will be presented in Chapter Four. Finally, in Chapter Five, I will focus on a comprehensive discussion and then a conclusion of this study. Implication and limitations of this study as well as recommendations for future studies will also be provided in the last chapter.

Chapter Two

Literature Review

Landmark Studies on Resilience

In the field of psychology, research on resilience and coping began in the 1970s (Kitano & Lewis, 2005) and has been expanded to psychopathology, developmental psychology, clinical social work and related fields. Emily Werner's Kauai Longitudinal Study and Norman Garmezy's Minnesota Risk Research (also named Project Competence) are perhaps the most well-known resilience research studies of children at risk in the U.S. Only later, was the term resilience used in these research studies. A brief review of these two landmark studies will be presented here.

Werner's Kauai Longitudinal Study. The Kauai Longitudinal Study is the classic and foundational study of resilience conducted by developmental psychologist Werner and her colleague beginning in 1954 (Werner, 1985; Werner & Smith, 1977, 1982). This study tracked the prenatal influences and the developmental path of high-risk multiethnic children (*N*=698) born in 1955 on the island of Kauai, Hawaii. Participants' parents and grandparents were semi-skilled or unskilled laborers who migrated from South East Asia (Japan, Philippines, and Hawaii). Two principle goals of this study were (1) to document participants' course of pregnancies and the outcomes from birth to ages 1, 2, 10, 18, and 32, and (2) to assess participants' physical, cognitive, and psychological development influenced by long-term consequences of biological and psychological risk factors and protective factors. Of the 698 children, this study had a primary focus on risk and the vulnerability of high-risk participants (*N*=201) who were exposed to perinatal stress, chronic poverty, and history of familial discord, divorce, and psychological

disorders. Although two-thirds of the high-risk participants showed maladaptive learning, social, and emotional responses, the researchers were impressed by one-third of the high-risk participants (*N*=72; 30 males, 42 females) who became competent, confident, and caring adults despite the high-risk circumstances. Later, the research project switched focus from a risk-oriented to a resilience-oriented study (Werner & Smith, 1982).

In Werner and her associates' multidisciplinary study, a research team that consisted of public health nurses, physicians, social workers, teachers, pediatricians, and psychologists were recruited to collect data throughout different phases of this longitudinal study. Data were collected from questionnaires, interviews, school reports, records of prenatal, hospital, labor, delivery, newborn, public health, educational, as well as records from social services agencies, local police, and family court. The following instruments (as cited in Werner & Smith, 1982) were administrated by the research team. At age 2: the Cattell Infant Intelligence Scale and Doll's Vineland Social Maturity Scale; At age 10: Primary Mental Abilities Test, Elementary Form, Bender-Gestalt Test, Wechsler Intelligence Scale for Children (WISC), individual Bender-Gestalt, Draw-A-Person, Graham-Kendell Memory for Design, Rorschach, Thematic Apperception Test (TAT); at age 18: the California Psychological Inventory (CPI) and the Nowicki Strickland Locus of Control Scale; at age 30: Rotter's Locus of Control Scale, and the EAS Adult Temperament Survey.

Results showed that "rearing conditions were more powerful determinants of outcome than perinatal trauma" (Werner, 1992, p. 263). Also, while a variety of risk factors that were associated with maladaptive adaptation in participants' childhood, adolescence, and adulthood were originally explored, as the longitudinal study progress,

Werner and her colleagues noticed a group of at-risk children who were vulnerable yet invincible. The research team began to look at protective factors that enabled vulnerable children to successfully cope with risk factors across various transitions to adulthood. In the findings, the researchers categorized protective factors in the following five clusters (Werner & Smith, 1982):

- *Cluster 1: Temperamental Characteristics.* A variety of caring persons, such as parents, siblings, teachers, mentors, coaches, spouses or mates who provided characteristics that nurture and stimulate individuals' positive responses.
- *Cluster 2: Skills and Values*. The skills, values, and spiritual faith that individuals obtain in reaction to plans, challenges, or responsibilities in various situations and developmental stages.
- *Cluster 3: Characteristics and Caring Styles of Parents*. Parents' competence that fosters children's positive self-esteem, such as parents' educational levels, ability to be a role model, and the set rules and structures at home.
- *Cluster 4: Supportive Adults.* Surrogate parents, such as grandparents, mentors, older siblings, sport coaches, who provide consistent care, foster trust, and also serve as gatekeepers.
- *Cluster 5: Opening Opportunities at Major Life Transitions*. Opportunities (e.g. education, vocation, and marriage) at major life transitions that pave the road for high-risk children to adapt to their adulthood.

The researchers followed participants' early childhood to age 32. The results suggested that emotional support from spouses, kinship, faith and prayers, as well as opportunities at major life transitions significantly contributed to adult resilience. The

Kauai Longitudinal Study is documented in five books: *The Children of Kauai* (Werner, Bierman & French, 1971), *Kauai's Children Come of Age* (Werner & Smith, 1977), *Vulnerable but Invincible* (Werner & Smith, 1982), *Overcoming the Odds: High Risk Children from Birth to Adulthood* (Werner & Smith, 1992), and *Journeys from Childhood to Midlife* (Werner & Smith, 2001). The authors concluded that "the most precious lesson that we choose to learn from this study is "hope" (Werner, 1992, p. 265) because hope is the central component found in the resilient participants that bring them a feeling of confidence to cope and succeed against the odds.

Garmezy's Project Competence. Beginning in 1961, Garmezy and subsequent researchers investigated children vulnerable to schizophrenia and other forms of psychopathology through the Minnesota Risk Research Project (Garmezy, 1970, 1971, 1974, 1975; Garmezy & Devine, 1984). In his empirical studies, Garmezy and his colleagues explored the development and competence of children of schizophrenic parentage. Despite the positive correlations between poor manifestations of competence and children's maladaptive behaviors, the researchers could not help but notice a large number of children who manifested high levels of competence and adaptation. These children had been originally labeled as at-risk due to genetic vulnerabilities and environmental adversities. As a result, Garmezy's research program evolved to become Project Competence with a focus on the study of stress-resistant children (Garmezy, 1978, 1981; Garmezy & Devine, 1984; Garmezy, Masten, & Tellegen, 1984). Switching from a pathological-oriented to a developmental-oriented focus, several waves of Project Competence studies were conducted.

Goals of the first wave of Project Competence were intended to (1) identify stress-resistant children who were exposed to different types of stressors, (2) explore characteristic patterns of adaptive children who show higher competence-related behaviors than their maladaptive cohorts, and (3) explore possible developmental factors that may differentiate control and experimental groups of children (Garmezy, 1987). Cohort I, drew from a community-based sample of families, was studied extensively by the researchers. Here, I present the review of Cohort I as follows:

Garmezy (1987) recruited a sample of families (*N*=200) from two contiguous elementary schools both located in a large city. Through the course of three years of research, data were collected from interviews with mothers and children, an individual achievement test, an abbreviated intelligence test, school records, as well as laboratory studies for the measurement of social cognition, problem-solving, divergent thinking, humor comprehension, humor appreciation, humor generation, delay of gratification, and impulsivity-reflectiveness. In addition to the researchers, social workers and psychology graduate students also served as interviewers.

Using correlational factor analyses and multiple regression, assets, family attributes, social comprehension, and family characteristics were found to be significant factors for participants' competence-related behaviors. (1) *Assets*: refers to IQ, SES, family attribute of stability and cohesion. Results showed higher competence and greater social engagement with peers were more likely to be found among children with greater assets particularly under stress. On the contrary, when under stress, disruptive behaviors were more likely to be found among children with fewer assets. (2) *Family Attributes*: refers to competence of the parents, parent-child relationships, family communications,

and parents' understandings of their child. Results revealed that in addition to higher SES and IQ, positive family attributes served as protective factors, especially for girls, in responding to stress. (3) *Social Comprehension*: refers to interpersonal understanding, problem-solving ability, humor comprehension, appreciation, and production. Results indicated that in addition to IQ and SES, social comprehension is a significant factor associated with children's social engagement. (4) *Family Characteristics*: refers to family stability and organization (e.g. family moves, marriages, jobs) and family cohesion (e.g. frequency of family activities, expressions of affection, rule setting, and degree of communication). Results suggested that family characteristics positively relate to children's intelligence and competence, especially under high stress levels. On the other hand, children with disadvantageous family characteristics and low SES tend to experience more stressful life events and manifest poorer competence and lower intellectual ability.

Through follow-up studies on the sample families, Project Competence evolved again and became the Project Competence Longitudinal Study (PCLS). PCLS continues to investigate children of participants into their adolescent, adulthood, and, hopefully, to their middle age of adulthood (Masten & Tellegen, 2012).

In his literature review, Garmezy (1993) concluded that (1) individual temperament and personality attributes, (2) family variables, and (3) social support were the most important core protective factors (with other possible factors not yet explored) that sustain individuals in stressful life events.

Theoretical Foundations of Highly Resilient Therapists

Richardson's Resiliency Model

Influenced by Flach's "Law of Disruption and Reintegration" (Flach, 1988, 1997), Richardson and colleagues (Richardson, Neiger, Jensen, & Kumpfer, 1990) proposed The Resiliency Model (Figure 2.1). According to Richardson (2002), resilience is referred to as a linear model that "depicts a person (or group) passing through the stages of biopsychospiritual homeostasis, interactions with life prompts, disruption, readiness for reintegration and the choice to reintegrate resiliently, back to homeostasis, or with loss" (p. 310).

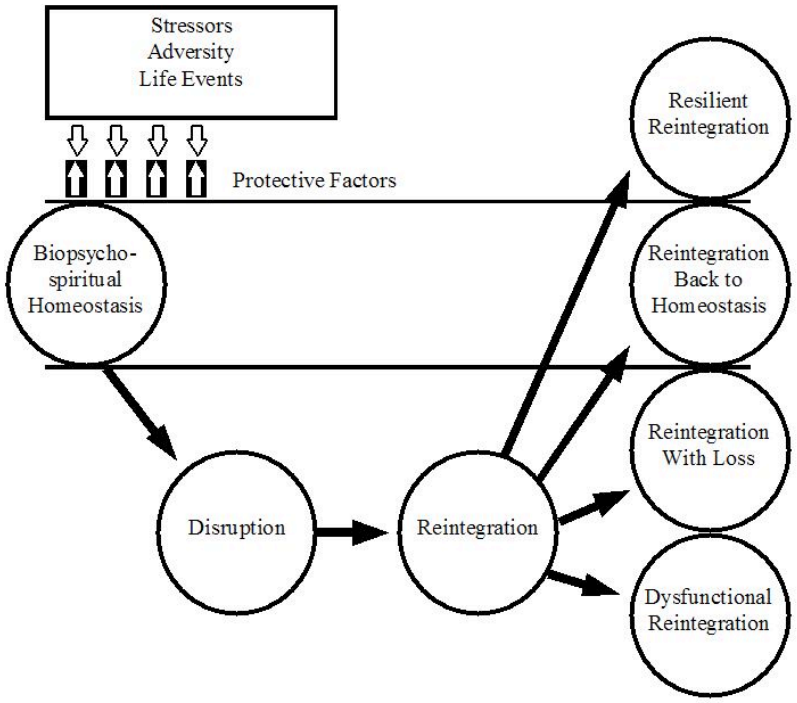


Figure 2.1 The Resiliency Model (Richardson et al., 1990; Richardson, 2002)

In The Resiliency Model, biopsychospiritual homeostasis is a state when "one has adapted physically, mentally, and spiritually to a set of circumstances whether good or

bad" (Richardson, 2002, p. 311). Individuals' biopsychospiritual homeostasis, called the "comfort zone," is constantly challenged by both life prompts and one's own perceptions and feelings about one's circumstances. The adaptation process begins when one's protective factors begin to interact with life events. One's resilience qualities are, therefore, fostered through the adaptation process. Once individuals are able to maintain a routine in coping with life prompts, they are able to maintain homeostasis, otherwise, disruptions occur. Disruptions may be unexpected (e.g. natural disasters, human tragedies, losing a job) or planned (e.g. career transitions, getting married, immigrations) and will result in emotions and introspection. Richardson (2002) referred disruptions to:

> An individual's intact world paradigm is changed and may result in perceived negative or positive outcomes. It means that a new piece of life's puzzle is there to potentially add to an individual's view of the world. To add to the piece of the puzzle, the pieces of one's paradigms that are affected by the new piece fall apart, thereby allowing the new piece to be incorporated into the worldview. (p. 311)

Once individuals are able to process emotions (e.g., hurt, loss, guilt, perplexity, confusion, and bewilderment) and move forward from dwelling in negative emotions and disruptive status, they are ready to begin the reintegration process. Four different outcomes may result from reintegration: *(1) Resilient Reintegration*: through the insights of introspection regarding disruptions, one restores, grows, and acquires resilience qualities*, (2) Reintegration Back to Homeostasis*: one is healed, able to "get past" (Richardson, 2002, p. 312) disruptions, and return to a comfort zone without particular gains or growth from the retrospective experience, *(3) Recovering With Loss*: one may appear to be healed through the introspection of disruptions while their hopes and

motivations fade away after the life prompts, and *(4) Dysfunctional Reintegration*: one engages in maladaptive behaviors as a way to cope with stressful life events. The Resilience Model has been supported by several dissertation studies investigating college students (Neiger, 1991), married women with dependent children (Dunn, 1994), and adult children of perceived alcoholics (Walker, 1996).

The Cycle of Caring

The Cycle of Caring (Figure 2.2) provides a comprehensive framework for our understanding of how and why mental health practitioners have to use their vulnerable side in order to successfully help clients—one after another. Based on his many years of research, teaching, workshops and clinical practice, Skovholt (2001, 2005) proposed this theoretical model to describe three phases of caring practitioners' one-way caring relationships in the helping process: *(1) empathetic attachment, (2) active involvement, and (3) felt separation*. Later in Skovholt and Trotter-Mathison (2011), a fourth phase *(4) re-creation* was added.

According to Skovholt (2005), in order to establish a successful and professional attachment without underattachment or overattachment, practitioners must use their caring side—"the underside of the turtle" (p. 88) instead of the hard shell. Mental health practitioners have to learn "how to be emotionally involved yet emotionally distant, united but separate" (p. 88). With a successful empathetic attachment, practitioners will be able to continually be involved in the one-way caring process until the time to separate and perform a professional termination with clients. Later, when working with the next client, caring practitioners reveal their caring side again and engage in a new Cycle of Caring.

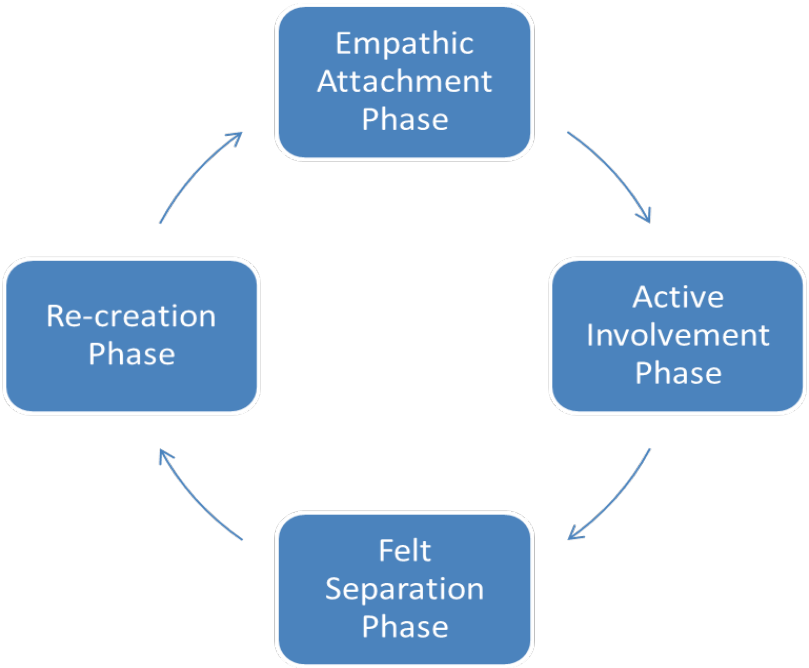


Figure 2.2 The Cycle of Caring (Skovholt, 2005)

Phases of Therapist/Counselor Development

Based on an *N*=100 qualitative interview study of therapists from various stages of their professional development, Skovholt and Rønnestad (1995) investigated the development of therapists and counselors and proposed a Therapist/Counselor Development model. The recent revision of a five-phase model of Therapist/Counselor Development was proposed in 2013 (Rønnestad & Skovholt, 2013). Based on developmental tasks and therapists' responses to challenging tasks, Rønnestad and Skovholt (2013) distinguished therapist/counselor development with the following five phases:

The Novice Student Phase: referred to graduate students in the mental health professions, including those who just begin practicum experiences. The developmental tasks of novice students are to be familiar with information, knowledge, and basic therapy/counseling skills learned in the class. Furthermore, for novice students, how to apply theories and skills when encountering real clients in their practicum as well as to maintain openness yet be selective of theoretical orientations and techniques are critical developmental tasks in this phase.

The Advanced Student Phase: referred to graduate students in their final stage of training. Supervised practicum or internship is usually the major part of the remaining requirement of the training. Similar to the developmental tasks of novice students, advanced students strive to comprehend knowledge, be familiar with basic therapeutic skills and assessment, and stay open yet be selective of theoretical orientations and techniques. Besides, advanced students in this phase begin to reconstruct "what therapy/counseling is" and their professional identities. In addition to gaining basic professional competence, practitioners in this stage also begin to encounter a new round of insecurity and vulnerability while realizing more about the complexity of psychotherapy and counseling.

The Novice Professional Phase: referred to novice mental health practitioners during their first two to five years of post-graduate work. The developmental tasks in this stage focus on the transition from the professional training to the professional world. Another important task is to (re-) confirm their professional identities/roles.

The Experienced Professional Phase: referred to mental health practitioners with certain years of postgraduate practice who are confident in working with various types of

clients and work settings. After years of practice, dealing with burnout, stagnation, boredom, or apathy is the primary developmental tasks in this phase. Also, practitioners in this phase are in a deeper search for integration and congruence between the work role and authentic self.

The Senior Professional Phase: referred to mental health practitioners who have more than 25 years of postgraduate clinical experience in a mental health profession. In addition to maintaining continually professional growth and professional vitality, as well as to continue ongoing integration of the professional self and personal self, senior professionals also begin to deal with tasks pertaining to adjustments of reduced workload and preparation for retirement due to age, and reducing energy and desire for an expanded self beyond work.

Developmental tasks and challenges in each phase of this model echo concepts in the Cycle of Caring (Skovholt, 2005) and The Resiliency Model (Richardson et al., 1990). Particularly, concepts in the Experienced Professional and Senior Professional Phases seem to overlap with constructs of resilient therapists.

Review of Studies on Resilient Therapists

A few existing studies that directly used the term *resilience* to study therapists' well-being will be reviewed here.

For his Walden University dissertation, David (2012) conducted a quantitative study examining the link between Compassion Fatigue and the level of *resilience* among mental health professionals (N=275). Participants were psychotherapists, social workers, counselors, nurses and doctors who work with trauma survivors or PTSD clients. Collins' (2007) definition of resilience for social workers (see Chapter 1) and other definitions of

resilience based on trauma-survivor studies (e.g. Hernandez et al., 2007) served as David's operational definitions for therapist resilience. In his study, the Professional Quality of Life Scale Version 5 (Pro-QOL 5; Stamm, 2009), a demographic questionnaire, and the Connor-Davidson Resilience Scale (CD-RISC; Conner & Davidson, 2003) were distributed through a web-based survey to self-identified trauma-related treating counselors for data collection. Using multivariate analysis, relationships between three compassion fatigue subscales (e.g., compassion fatigue, burnout, compassion satisfaction) and resilience were examined. Specifically, two-way ANOVA was conducted to assess the predictor variables in the Pro-QOL 5 (Stamm, 2009) and criterion variables in the CD-RISC (Conner & Davidson, 2003); Three one-way ANOVAs and a multiple regression were conducted to examine criterion and continuum variables in the demographic questionnaire and their association with the CD-RISC (Conner & Davidson, 2003).

David's (2012) findings suggested that compassion fatigue, burnout, and compassion satisfaction together have a correlation with the level of resilience ($F = 32.89$, $p < .001$). But, individually, only burnout ($B = -0.92$, $p < .001$) and compassion satisfaction ($B = 0.94$, $p < .001$) were found to be predictors of individual's level of resilience. In other word, compassion fatigue, by its own, was found to have no predictive power for resilience. Additionally, counselors' gender, years of clinical experience, educational level, and the combination of years of experience and number of trauma clients treated, were found to have no associations with resilience.

David's (2012) dissertation study emphasizes the importance of resilience development among mental health providers. It contributed to the empirical study of

counselor resiliency research by examining the participants' level of resilience through two instruments—the Pro-QOL 5 (Stamm, 2009) and the CD-RISC (Connor & Davidson, 2003). Also, different from the Pro-QOL 5, the CD-RISC was not originally developed for mental health practitioners, and no validity studies have been conducted for its use with this population. Thus, by comparing results between the CD-RISC and the Pro-QOL 5 among counselors, David's study served as a validity study for the CD-RISC. In addition, David's study provided empirical evidence of the positive correlation between resilience and compassion satisfaction, as well as a negative correlation between resilience and burnout. Moreover, this study also provided evidence for the non-correlative relationship between the level of resilience and gender, years of practice, and education level. On the other hand, limitations of this study also need to be kept in mind. For example, no pretest was performed to ensure consistency of participants' individual differences in compassion fatigue, burnout, and compassion satisfaction, as well as the level of resilience, which may weaken the validity of the results.

In Lidderdale's (2009) Western Michigan University dissertation on Phenomenological Study of Resilience in The Lives of White, Midlife Lesbian Psychologists in Clinical Practice, she explored the essence of *resilience* in the lived experience of psychologists who are lesbians and in midlife. In her study, Luthar's (2003) definition of resilience: "manifestation of positive adaptation despite significant life adversity" (as cited in Lidderdale, 2009, p. 13) was adopted as her working definition of resilience. To investigate both personal and professional experiences of resilience among lesbian psychologists, Lidderdale asked: "How do lesbian psychologists experience resilience in their lives? How do these women make meaning of their experiences of

resilience? How do these psychologists experience their own resilience impacting their counseling work with clients?" (p. 94). Through a peer nomination procedure, lesbian clinicians (*N*=7) with at least fifteen years of post-doctorate clinical experiences were recruited for initial and follow-up interviews. Data were analyzed through phenomenological methods. Six common themes were found:

Theme 1. Resilience is a Complex, Interactive Process

- General Stage One in the Resilience Process: Experience of Disruption from Challenge
- General Stage Two in the Resilience Process: Response to Challenge
- General Stage Three in the Resilience Process: Integration through Meaning Making

Theme 2. Resilience Initiates a Significant Challenge

- Challenges from Relationships
- Challenges from Health Concerns
- Challenges from Social Oppression in Contexts

Theme 3. Resilience Involves Responding to Challenge with Internal and/or External Actions

- Internal Actions Taken in the Resilience Process
- External Actions Taken in the Resilience Process

Theme 4. Resilience is Facilitated by the Use of Internal and External Resources

- Internal Resources Used in the Resilience Process
- External Resources Used in the Resilience Process

Theme 5. Resilience Process Results in Individual and Environmental Outcomes

- Positive Individual Outcomes from the Resilience Process
- Negative Individual Outcomes from the Resilience Process
- Environmental Outcomes from the Resilience Process

Theme 6. Meaning Making from the Resilience Process Occurs Cumulatively Across the Lifespan

- New Understandings of Self Emerge from the Resilience Process
- New Understandings of Self in Relation to Others Emerge from the Resilience Process
- New Understandings and Perspectives of Life Emerge from the Resilience Process

(Lidderdale, 2009, p. 163-221)

Lidderdale (2009) identified Theme 1 and Theme 6 as the meta-themes because they interlinked and were related to other common themes. While Theme 1 represented the general resilience process among participants, Theme 6 is participants' reflections on the on-going resilience process across their lifespan. In addition, Theme 2, 3, and 4 are risk factors, protective factors, and coping strategies/resources, with Theme 5 as the responding and coping results. More importantly, in Lidderdale's study, the internal resources—resources within lesbian psychologists that are used in responding to challenges are similar to questions about the characteristics or an inner/innate force among highly resilient therapists that is being addressed in the present study. The most common four inner resources used by lesbian psychologists were: "(a) passion, (b) an inner sense, (c) value of an inner life as important, and (d) value of authenticity combined with a sense of justice" (p. 182). Some other common inner resources include: "(a) action

oriented; (b) determination; (c) curiosity and interest in things, people, and relationships; (d) analytic nature; (e) creativity and intellectual ability; and, (f) a value of relationships as important" (p. 182).

Based on the research findings, Lidderdale provided the following General Structural Description of Resilience to conclude the essence of resilience:

> Resilience is a complex, dynamic and interactive process in which (1) an individual experiences a significant challenge that causes a change in her/his life path or life perspective; (2) an individual responds to and overcomes the challenge through internal and/or external actions; (3) in responding to the challenge an individual relies on internal resources (e.g., abilities, attitudes, skills, values); (4) in responding to the challenge an individual relies on external resources (e.g. relationships, opportunities, status); (5) an individual emerges from the challenge with positive outcomes (e.g., growth, new skills, goals, attitudes); (6) an individual also emerges from the challenge with some negative outcomes (e.g. stress, loss, health issues); (7) an individual's actions result in changes related to the environment (e.g. relationship to environment, perspective on environment, elements of the environment); (8) an individual forms a new system of meaning or perspective of life as a result of the resilience experience; (9) an individual experiences the resilience process across the lifespan with cumulative effects; and (10) the accumulative experience of the resilience process has an outcome of increasing an individual's awareness of others and motivation to foster resilience within the individuals environment.

(Lidderdale, 2009, p. 228-229)

Lidderdale's study concentrates on psychologists' resilience process in their lived experiences. It contributed significantly to the research line on resilient therapists. Particularly, with the scarcity of research pertaining to therapists' resilience, this study makes a major contribution in understanding individual characteristics and inner resources that sustain therapists' resilient responses. However, when applying to the purpose of this present study, we need to be mindful that individual characteristics and inner resources in Lidderdale's study are a combination of psychologists' personal and professional lived experiences, rather than professional-resilience-specific findings. Some limitations of this study also need to be kept in mind. For example, the homogeneity of participants' gender, sexual orientation, demographics, level of education, and racial cultural background may limit the applicability of research findings among other groups. Also, the author served as the only person for data analysis, this may create researcher biases.

Stemming from Mullenbach's (2000) dissertation, Mullenbach and Skovholt (2011) co-authored a book chapter to address both risk and protective factors associating with wellness and professional *resiliency* among peer-nominated expert mental health practitioners (N=10; male=3, female=7) with an average of 31 years of practice experience. In Mullenbach's (2000) dissertation study, she defined professional resiliency as "a dynamic pattern that, over time, is marked by positive adaptation to an array of normal stress factors as well as other non-normative incidents or experiences that are acute in nature" (p. 11). Two semi-structured interviews consisting of 22 open-ended questions were conducted within each participant. An inductive data analysis was utilized

to investigate high-level stressors and self-care strategies among research participants. The following five categories and twenty themes were found in this study:

Category A: Professional Stressors

Theme 1: Participants are stressed by issues that challenge their competency

Theme 2: A frozen therapy process is highly stressful for participants

Theme 3: Breaches in peer relationships are stressful

Theme 4: Intrapersonal crises negatively impact the professional role

Category B: Emergence of the Expert Practitioner

Theme 1: Participants learned role limits and boundaries

Theme 2: Over time, participants experienced less performance anxiety

Theme 3: With experience, participants moved from theory to use of self

Theme 4: Participants view attachment and separation as a natural process

Theme 5: Participants understand human suffering at a profound level

Category C: Creating a Positive Work Structure

Theme 1: Mentor and peer support was critical at the novice phase

Theme 2: Participants have ongoing and enriching peer relationships

Theme 3: Multiple roles are protective factor

Theme 4: Participants create health-promoting work environments

Category D: Protective Factors

Theme 1: Participants directly engage highly stressful professional dilemmas

Theme 2: Participants confront and resolve personal issues

Theme 3: Highly engaged learning is a powerful source of renewal

Category E: Nurturing Self through Solitude and Relationships

Theme 1: Participants foster professional stability by nurturing a personal life

Theme 2: Participants invest in a broad array of restorative activities

Theme 3: Participants construct fortifying personal relationships

Theme 4: Participants value an internal focus

(Mullenbach & Skovholt, 2011, p. 221)

In Mullenbach and Skovholt (2011), Category A, Professional Stressors, included elements identified as risk factors; Categories B, Emergence of the Expert Practitioner, included lessons and strategies learned from professional work; Category C, Creating a Positive Work Structure, included elements for proactive self-care strategies in the work place; Category D, Protective Factors, described mindsets for choosing positive cognitions rather than cognitive disruptions; Category E, Nurturing Self through Solitude and Relationships, included elements for proactive self-care strategies in one's personal life. Categories B, C, and D, together are identified as internal and external protective factors. The researchers suggested professional wellness and burnout prevention can result from critical components provided from the combination of categories A, B, C, and D.

With a purpose to understand therapists' emotional wellness and professional resiliency, Mullenbach and Skovholt (2011) made significant contribution to the research line on highly resilient therapists. The major limitation of this research is that the peer-nominated master therapists, who served as research participants, were mainly private

practitioners, and all were Caucasians. Therefore, one must be cautious in applying the results of this study. Also, repeated interviews of participants may also contribute to data basis. When applying to this present study, it is important to note that Mullenbach and Skovholt's study (2011) has a central focus on identifying stressors (risk factors) and self-care/coping behaviors that contribute to master therapists' emotional health and professional resilience, while the major focus of this present study is to identify characteristics or traits that sustain therapists' resilience. Also, with a sample group of master therapists, rather than resilient therapists, findings of Mullenbach and Skovholt's study should be used cautiously. For example, the "self-righting mechanism" or "force/energy" that drives one to become a master therapist may not be the same one that drives a therapist to become a resilient therapist.

In the field of social work, Collins (2007) also noticed the research tendency to pay more attentions to the deficient side of social workers. Given the increasing attention given to resilience among children and adolescent, Collins found that little was studied among adults and social workers. Since his published article "Resilience, Positive Emotion and Optimism" (Collins, 2007) is a conceptual article, a detail review will not be provided here. Yet, Collins' definition and insights about *resilience* for adults and social workers seem parallel with this present study. He referred to resilience as "an adaptive state and personality trait evident in many people, including social workers, but it is influenced by many variables, such as culture" (Collins, 2007, p. 255). Collins (2007) also emphasized that "hope" and "optimism" (p. 263) are significant personal characteristics for social workers to sustain positivity in their work.

Likewise, based on his extensive teaching and research on caring practitioners' development, self-care, and burnout prevention, Skovholt summarized his years of work in his book *The Resilient Practitioner—Burnout Prevention and Self-Care Strategies for Counselors, Therapist, Teachers, and Health Professionals* (2011). Although a clear definition of professional resiliency was not provided in his book, self-care and *resilience* development seemed to go hand in hand in Skovholt's articles. For example, according to the Skovholt Practitioner Professional Resiliency and Self-Care Inventory (Skovholt, 2010), when a caring practitioner is able to maintain high levels of professional vitality and personal vitality, as well as to maintain low levels of professional stress and personal stress, they are more likely to become highly resilient practitioners. In other words, a balance between other-care and self-care is the key for maintaining resiliency. In his 2012 article, Becoming a Resilient Practitioner (Skovholt & Trotter-Mathisen, 2012), Skovholt summarized his years of research on caring practitioners' self-care and resilience development. He perceived self-care as a process of burnout prevention and resiliency development in practitioners' everyday life. Skovholt (2012, p. 116-140) recommended the following Eleven Essential Resilient Practitioner Tasks for caring practitioners:

Task 1: Lose One's Innocence About the Need to Assertively Develop Resiliency and Self-Care Skills. Similar to the use of seat belts, sunscreen, smoke alarm, brushing and flossing, caring professionals have to recognize hazards and prevent the danger.

Task 2: Develop Abundant Sources of Positive Energy. One or more gushing wells that provide positive energy (e.g. joy, peace, contentment, pleasure, elation) are essential for caring professionals to sustain long-term practitioner vitality.

Task 3: Relish the Joy and Meaning of the Work as a Positive Energy Source. Caring professionals have to keep in mind the privilege of participating and making a difference in the client's journey of struggles, and really help the other while witnessing the profundity of human resiliency.

Task 4: Search for Empathy Balance. A resilient caring professional will self-monitor the balance between empathetic attachment to others' needs and self-care of one's own needs. He or she practices "plug, unplug, and re-plug" between personal and professional life in a self-sustaining way.

Task 5: Develop Sustaining Measures of Success and Satisfaction. A resilient caring professional is realistic about the ambiguous reality for measuring their success at work. They accept the powerlessness of the nature of the job nature (concrete vs. ambiguous) yet maintain faith.

Task 6: Create a Greenhouse at Work. If a supportive and positive peer and supervisory relationship is not available, resilient practitioners will build their own "greenhouse" in the work environment that empowers and maximizes their potential.

Task 7: Connect with Your Own Spirituality. A resilient caring practitioner sustains his or her personal life through spiritual connections that bring peace, joy and hope.

Task 8: Finding Balance to the Imbalance of Too Many One-Way Caring Relationships in One's Personal Life. Resilient practitioners are able to limit one-way caring relationships in one's personal life. They seek empathy and balance through maintaining a reasonable caseload in professional life and "give and take" friendships in personal life.

Task 9: Max Out the Body as a Source for Positive Energy. Resilient practitioners maintain a good amount of exercise, sleep, nutrition, meditation and relaxation, and, love and affection in daily life.

Task 10: Long-Term Continual Focus on the Development of the Self. Resilient practitioners seek on-going learning and growing experiences in becoming a master therapist in professional life and a mature person in personal life.

Task 11: Have Fun and Be Playful. Resilient practitioners have abundant resources for fun and being playful, such as hobby, vacations, and recreations that create laughter in personal life.

Summary

In the present study, reviews of literature that directly used the term "resilience" as the concept to investigate therapists' resilience was the central focus of this chapter. However, a paucity of published studies was found. Also, among the few existing studies, risk factors, stressors, challenges or attributions of therapists' deficits seemed to be the common research focus. What causes therapists' deficits and how to cope (e.g., burnout prevention, stress coping, self-care strategies, etc.) in order to require balance and remain resilient were the emphases of these existing resilience studies, which parallels later reviews on risk- and protective-factor oriented studies. Also, with respect to the definition of the highly resilient therapist, most articles reviewed above were prone to adopt existing definitions that were not tailored specifically to the work of counselors and therapists. Mullenbach's (2000) dissertation study was the only one that attempted to develop a definition of professional resiliency specifically for therapists, which helped inform my intention to better define what it means to be a resilient therapist. In addition,

inner resources found in Linddale's study (2009) and optimism proposed by Collins (2007) seem closely related to another goal of this present study—to explore characteristics that sustain therapists' resilience.

Overview of Studies Related to Resilient Therapists

Although the term *resilience* may not be used in describing therapists' well-being in many published articles, risk factors and protective factors related to therapists' work have long been investigated. In this section, an overview and synthesis of findings related to studies on risk factors and protective factors among therapists will be presented.

Risk-Factor Oriented Studies

From the pathological lens, negative effects of counseling work upon counselors are well studied in psychology related fields. Prevalent studies pertaining to these negative effects have been focused on vicarious trauma, secondary traumatic stress, compassion fatigue, and burnout. The first three terms are often described as overlapping in the literature. Vicarious Trauma is "a process of [cognitive] change resulting from [chronic] empathic engagement with trauma survivors" (Pearlman, 1999, p. 52). Cognitive changes defined here were distinguished as the pervasive and negative change of one's sense of self, worldviews, and spiritual beliefs after directly working with traumatized clients (Pearlman, 1997; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995).

Compassion Fatigue and Secondary Traumatic Stress are oftentimes used interchangeably. Charles Figley, a leading scholar in compassion fatigue research, defined Secondary Traumatic Stress (Compassion Fatigue) as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced

by a significant other-the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley,1995, p. 7). It is also "a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of bearing witness to the suffering of others" (Figley, 2002b, p. 1435). Secondary Traumatic Stress has nearly identical symptoms to those of post-traumatic stress disorder (PTSD) described in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* (American Psychiatric Association, 2013). Similar symptoms included recurrent and involuntary thoughts/memories/nightmares, detachment or estrangement, insomnia, persistent avoidance of traumatic-event related feelings associated with clients (APA, 2013; Figley, 2002a).

Burnout, on the other hand, is often nurtured negatively in a more general and broader spectrum way comparing to vicarious trauma and secondary traumatic stress (compassion fatigue) that are mainly caused by repeated exposure to high trauma-related clients. The term "burnout" was first introduced in Freudenberger's (1974) article, and it becomes a prevalent term during recent decades for studies related to work exhaustion and depletion in a variety of occupations. Burnout refers to "a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations" (Pines & Aronson, 1988, p. 9). From the perspective of the social and organizational environment, Christine Maslach, a major scholar in burnout research, defined burnout as "the index of the dislocation between what people are and what they have to do. It represents an erosion in values, dignity, spirit, and will—an erosion of the human soul" (Maslach & Leiter, 1997, p. 17); in other words, "job burnout is a psychological syndrome that involves a prolonged response to stressors in the workplace.

Specifically, it involves the chronic strain that results from an incongruence, or misfit, between the worker and the job" (Maslach, 2003 b, p. 189). According to Maslach and her colleagues, job burnout can be future understood through the following three dimensions. (1) *Exhaustion*: a state of emotional depletion results from excessive demands and expectations from clients, colleagues, supervisors and organizations; (2) *Depersonalization*: a state of cynicism, negativity, or detachment results from social interactions in the workplace; (3) *Inefficacy*: a state of professional inadequacy results from lack of progress in client-related or administrative related efforts. One's sense of personal accomplishment is therefore reduced (Maslach, 1998; Maslach, Schaufeli, & Leiter, 2001).

Personal Risk Factors. Abundant research has investigated personal risk factors that might have caused or served as predictive factors for the negative effects of counseling work. Examining therapist's childhood trauma history seemed to be a prevalent sub-line of risk-factor oriented studies. For example, VanDeusen and Way (2006) examined counselors' childhood maltreatment history and its relation to clinical work with sexual abuse victims or sexual offenders. Through an anonymous survey, participants (N=573) were recruited from the Association of the Treatment of Sexual Abusers (ATSA) and the American Professional Society on the Abuse of Children (APSAC). Using the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), participants' childhood maltreatment histories were assessed through various forms (e.g. emotional, physical, and sexual abuse). Employing Trauma Stress Institute Belief Scale (TSIBS-R-L; Pearlman, 2003) and its later version: Trauma Attachment Belief Scale (TABS; Perlman, 2003), participants' self-esteem and self-intimacy were examined.

Results indicated an association did exist between participants' emotional neglect history and trust of others. Participants' emotional neglect history was also associated with participants' intimacy with others. Furthermore, any or multiple forms of participants' maltreatment history were found to be associated with intimacy with others and multiple forms multiple maltreatment history.

Later, Way, VanDeusen and Cottrell (2007) conducted a follow-up study to further investigate age and gender differences among the participants (*N*=38, male=150 and female=233) who participated in VanDeusen and Way's 2006 study. Results of sequential regression analysis indicated a significant relationship between self-intimacy versus age, gender, and history of emotional neglect. Younger counselors were found to have higher cognitive disruptions about self-intimacy than older counselors. Male counselors were found to have higher cognitive disruption about self-esteem and self-intimacy than female counselors.

Similar findings pertaining to childhood abuse history as a risk factor for therapists' vicarious trauma were also indicated in earlier studies (Pearlman & Mac Ian, 1995; Kassam-Adams, 1995; Ghahramanlou & Brodbeck, 2000; Nelson-Gardell & Harris, 2003). However, inconsistent findings on therapists' childhood abuse history as a risk factor were also found in other studies. For example, in Follette, Polusny, and Milbeck's (1994) quantitative study, the link between therapists' (*N*=225) personal trauma history, caseload with sexually abused clients, and symptoms of vicarious trauma was examined. Results showed that no significant correlation was found between therapists' childhood abuse history and negative clinical responses resulting from working with clients experiencing childhood abuse. Follette et al. (1994) concluded that therapists' personal

trauma history and their caseloads of sexual trauma clients seemed to not be associated with therapists' vicarious trauma related symptoms.

Similar results were also found in Benatar's (2000) qualitative study. Research participants (*N*=12), consisting of counselors with histories of childhood abuse and those without abusive history, all worked with sexual abused clients. Participants were interviewed for this study. Results revealed no evidence that counselors' vicarious trauma symptoms were related to childhood abuse history.

Studies of the risk factor of childhood trauma history depicted a sub-line of the trend of risk-factor oriented studies. With regard to other prevalent risk factors, similar to literature discussed above, age and years of clinical experiences were often examined (Arvay & Uhleman, 1996; Ghahramanlou & Brodbeck, 2000). Other prevalent person risk factors identified in literature included therapists' educational level (Baird & Jekins, 2003), "social anxiety," "escape coping," and "low confidence" (Leiter & Harvie, 1996. p. 98), destructive mindsets (i.e. well-trained counselors do not need self-care because they were immunized from professional deficiency) (Barnett, Baker, Elman, & Schoener, 2007), and lack of knowledge about how to practice self-care (Sapienza & Bugental, 2000) were also identified as personal risk factors for therapists.

Also perceiving risk factors from the individual level, Thomas Skovholt, based on years of his research on counselor development and burnout prevention, identified the following 20 Hazards (Skovholt & Trotter-Mathison, 2011, p. 106-138) that caring practitioners often encounter during their practice:

Hazard One: They Have an Unsolvable Problem. Clients are stuck in a problem that they cannot avoid or solve for a long time. Stress occurs when caring professionals

expect to provide immediate and strong impact that leads to visible impairment by the client.

Hazard Two: They Are Not Honors Students. Caring professionals tend to forget that their clients are unlike honor students who can always learn, grow, and progress anywhere. Caring practitioners often develop feelings of incompetence when anticipating positive changes or success that does not happens after providing helps.

Hazard Three: They Have Motivational Conflicts. Motivational conflicts occur when clients' progress means that they have to lose secondary gains (i.e. a monthly disability benefit that relates to a depression diagnosis). Conflicts also occur when clients are involuntarily mandated to services.

Hazard Four: The Readiness Dance; There is Often A Readiness Gap Between Them And Us. Feelings of ineffectiveness occur when caring professionals are overcommitted, overprepared, or more ready than clients and are unable to recognize other's developmental, cognitive, or psychological readiness.

Hazard Five: Sometimes They Project Negative Feelings Onto Us. Clients often carry excess baggage containing painful, negative, or hurt feelings from past interactions with powerful adults in their lives such as authority figures or caring professionals. Caring professionals can be attacked when they are unaware of the resentment, anger, or resistance coming from the dynamic of projection and transference.

Hazard Six: Sometimes We Cannot Help Because We Are Not Good Enough. Stress occurs when caring professionals are unable to make a positive change in clients because the caring practitioners' demographics, life experience, or specialized skills mismatch with the needs of the client.

Hazard Seven: They Have Needs Greater Than The Social Service, Educational, or Health System Can Meet. Feelings of powerlessness occur due to the inadequate systematic care or resource that clients need to enhance their success.

Hazard Eight: The Inability To Say No—The Treadmill Effect. Exhaustion, overextension, indifference or apathy occur when caring practitioners let their good intentions and heroism striving take over rather than setting limits and saying no.

Hazard Nine: Living in An Ocean of Stress Emotions. The nature of a caring practitioner's job is to be exposed to and involved in the negative energy released from clients' emotional distress, like a form of a professional toxic. Emotional stress occurs when practitioners underestimate the intensity and scope of the toxic agent coming from the client's human distress.

Hazard Ten: Ambiguous Professional Loss—Ending Before The Ending. Exhausting stress can be caused by the client's ambiguous, unexpected closure of professional relationships without an opportunity for the caring practitioners to say goodbye or to know the fruits of their work.

Hazard Eleven: The Covert Nature of The Work. Professional practitioners cannot share the details of their work life—stress or success—outside of the professional context due to privacy and confidentiality. Caring practitioners' needs to be understood and receive social support have to be compromised.

Hazard Twelve: Constant Empathy, Interpersonal Sensitivity, and One-Way Caring. Even when greeted by client negativity (Hazard 5), caring practitioners must care for the other. They become vulnerable during the empathy process when the temptations

of countertransference is sensed. Risks increase when the one-way caring relationship is broken due to a lack of an ability to continue caring.

Hazard Thirteen: Elusive Measures of Success. Powerlessness often occurs when caring professionals are challenged to develop an elaborative and textured understanding of the client's changes. It is difficult to distinguish between the elusive measurements of realism, idealism, and perfectionism in the ambiguous and murky world of the caring professional.

Hazard Fourteen: Normative Failure. One challenge of the helping profession is the lack of concrete standards of success, which explain the term "normative failure." Distress occurs when caring professionals are unable to integrate the element of normative failure into their professional self-concept.

Hazard Fifteen: Regulation Oversight and Control by External, Often Unknown Others. Stress often occurs, or even increases when caring practitioners have less control over external factors, such as regulations, rules and increased administrative tasks that contradict with the need to offer quality services and manage excessive time demands.

Hazard Sixteen: Cognitive Deprivation and Boredom. This hazard occurs when caring professional feel bored due to the satiation of curiosity, novelty, or challenges that used to stimulate their intellectual growth or professional competence.

Hazard Seventeen: Cynical, Critical, Negative Colleague, and Managers. Stress occurs when practitioners are surrounded by a working environment with cynicism, criticism, and negativism, rather than a supportive environment where supervisors and positive colleagues mutually create a stress-buffering effect. This hazard is related to organizational risk factors.

Hazard Eighteen: Legal and Ethical Fears. Threats occur when caring professionals are wrongly accused of incompetence, and unethical or illegal behaviors.

Hazard Nineteen: Practitioner Emotional Trauma. Going beyond Hazard 9 about distress emotions, vicarious traumatization or secondary trauma stress occur because caring practitioners repeatedly listen to and absorb clients' trauma. Different from hazard 5, clients' intense affect (rudeness, anger outbursts, hostility, vernal threats, etc.) also can cause practitioners' emotional trauma.

Hazard Twenty: Practitioner Physical Trauma. Stress, anger, fear, and despair occur if caring professionals or their families' safety is threatened by current or past clients.

Organizational Risk Factors. A synthesized review of organizational risk factors that were prevailingly investigated in published literature will be provided here. It is worthy of note that some literature that examined personal risk factors also investigated organizational risk factors in the same studies.

Organizational risk factors such as caseload, work hours, availability of supervision (Pearlman & Mac Ian, 1993; Follette et al., 1994, Kassam-Adams, 1995), and level of trauma-related client exposure (Chrestman, 1999; Schauben & Frazier, 1995) are prevalent topics in relation to vicarious trauma, professional burnout, and compassion fatigue. In Raquepaw & Miller's (1989) study, researchers investigated the relationship between caseload and work stress among psychologists (N=68). Results showed a positive association between perceived excessive caseload, job dissatisfaction, and professional burnout. In another study pertaining to professional burnout, Rosenberg and Pace (2006) intended to know predictors of burnout. Research participants were marriage

and family therapists (*N*=116) recruited from American Association of Marriage and Family Therapy (AAMFT). Results showed that the number of weekly work hours was associated with therapists' fatigue and stress. Researchers also concluded that quality of supervision was another risk factor associated with professional burnout. Likewise, in order to understand the link between job satisfaction and clinical supervision, substance abuse counselors (*N*=505) were recruited in Evans and Hoheshi's (1997) study. Researchers found that lack of or a poor quality of clinical supervision and support significantly were related to therapist' dissatisfaction in the work place.

Risk-factor oriented studies of therapists have been the mainstream research for decades; therefore, it is not surprising to find a few systematic literature reviews aiming to investigate the prevalence and trend of professional burnout across the mental health professions. In a systematic literature review pertaining to professional burnout, Leiter and Harvie (1996) examined research published between 1985 and 1995 across a variety of mental health disciplines. Researchers concluded the most common personal and environmental risk factors contributing to professional burnout were excessive caseload, lack of resource for clients, and inadequate social support from professional and personal relationships. Likewise, using the work of Maslach and Leiter (2005), Maslach, Schaufeli, and Leiter (2001), and Schaufeli and Enzmann, (1998), Maslach and Leiter (2008, p. 500-501) identified seven domains that may best synthesize organizational risk factors:

Domain 1. Workload: overloaded job demands cause exhaustion and depletion.

Domain 2. Control: role ambiguity or conflicts caused by high work demands yet low personal control in the work place.

Domain 3. *Reward*: lack of self-efficacy, satisfaction, and recognition by low financial, organizational, or social recognition and rewards.

Domain 4. Community: lack of a sense of community due to insufficient support from social interactions with supervisors and coworkers.

Domain 5. Fairness: feelings of unfairness and inequality caused by imbalanced reciprocity or social exchanges.

Domain 6. Values: value conflicts caused by the gap between individual and organizational values.

Domain 7. Job-Person Incongruity: perceived mismatch or misfit between individuals and the work environment.

Protective-Factor Oriented Studies

Coping Mechanisms. Therapists' coping mechanisms, such as protective practices, self-care behaviors, or stress coping strategies were investigated in a variety of published literature and are related to the study of resilient therapists. It is worthy of note that often suggested coping mechanisms were written as advice addressed in the discussion, recommendation, application, or conclusion sections at the end of published literature. They could be "the side-product" of risk-oriented factor studies that meant to examine risk factors or negative effects of counseling work. A synthesized review of protective factors and coping mechanisms investigated in published literature will be the main focus of this section.

Focusing on the protective factors in practice, Harrison and Westwood (2009) conducted a qualitative study in order to investigate protective practices that prevented counselors from suffering from vicarious traumatization. Participants (N=6), working

with traumatized clients were selected by peer nomination. These master mental health therapists ranged in age from 49 to 59 years old, with a range of 10 to 30 years of clinical experiences. There were participants of both genders and of diverse sexual orientations, and spiritual, as well as racial backgrounds. Initially, potential participants were "peer and organizationally nominated" (p. 206) on the basis of educational level, years of professional experience, and "self-identified as having managed well in this work" (p. 206). Later, potential participants were screened with the Professional Quality of Life: Compassion Fatigue and Satisfaction Subscales, R-III (*Pro-QOL*, Stamm, 2003) and the Burn Out and Compassion Fatigue subscales of the Pro-QOL, in order to ensure good quality of pre-research consistency. Through in-depth interviews and the Lieblich, Tuval-Mashiach and Zilber's (1998) typology of narrative analysis, researchers examined patterns of protective practices among participants. Thematic content analyses of participants' narratives were the primary focus of this study. Results of Harrison and Westwood's study yielded the following nine themes:

Theme 1: Countering Isolation in Professional, Personal and Spiritual Domains of Life

Theme 2: Developing Mindful Awareness: Integrated Practice of Spirituality

Theme 3: Consciously Expanding Perspective To Embrace Complexity

Theme 4: Active Optimism

Theme 5: Holistic Self-Care

Theme 6: Maintaining Clear Boundaries and Honoring Limits

Theme 7: Exquisite Empathy

Theme 8: Professional Satisfaction

Theme 9: Creating Meaning

(Harrison & Westwood, 2006, p. 208-213)

In theme 1, therapists restored balance by involving professional, personal, and spiritual relationships that had adverse risks from therapeutic relationships. Additional protective factors found in this theme included: clinical supervision, organizational support, training, professional development, diverse professional roles, and personal and spiritual connections. In theme 2, when therapists faced the complexity and ambiguity of suffering, developing mindful awareness was perceived as a protective practice. It increased therapists' ability for appreciation, toleration, maintaining multiple perspectives and hopes as well as helped therapists to separate personal and professional realms. In theme 3, when therapists experienced a sense of despair, they performed positive practices by using imagery, metaphor, self-talk, or professional connections with an intention to consciously challenge their negative cognitions. Therapists strived to extend their perspectives to recognize the beautiful, joyful, and growing sides of pain and suffering. In theme 4, therapists employed positive practices not only to maintain an optimistic faith, trust, and belief, but also to take proactive action for problem solving. Sometimes it takes a very small step for positive change. A protective practice in theme 5 referred to therapists' physical, mental, emotional, spiritual, and aesthetic aspects of self-care. Self-care strategies that help separate the realms of personal and professional life were considered a form of protective practice. In theme 6, therapists held realistic, rather than confused or fuse professional relationships and expectations as a form of protective practice. Theme 7 referred to therapists' ability to engage in intimate therapeutic attachment with clients and how it served as a protective factor that sustained therapists'

work. In themes 8, therapists' satisfactions from effective, highly-skilled, meaningful, and rewarding work were perceived as a protective factor. In theme 9, therapists' ability to make meaning of each therapeutic work relationship with clients was a form of protective practice.

Several strengths and weakness of this study are noteworthy. First, the study enriched the research line on protective practice and filled the gap between risk-factor- and protective-factor-oriented studies of counselors. Two levels of screening processes consisted of Pro-QOL and the Burn Out and Compassion Fatigue subscales of the Pro-QOL, is another strength that ensured participants' individual consistency of resiliency status prior to the study. Nominated diversity of research participants' racial, spiritual, and sexual orientation backgrounds were strengths of this study and made this study more generalizable. On the other hand, this study had a small sample size (N=6); one must be cautious in applying the results of this study. Nonetheless, the validity of "six-peer-nominated master therapists" was questionable. For example, one required criteria for Harrison and Westwood's (2006) purposeful peer nomination was "self-identify as having managed well in this work." In a confidential peer nomination process, how researchers obtained potential participants' self-perception about their own work was not indicated. In addition, the trustworthy of the purposeful sampling procedure was not clearly described. Their study stated, "a purposeful sampling procedure was used to recruit peer and organizationally nominated therapists" (p. 206) who met required criteria, "potential participants were recruited through flyers distributed through professional networks" (p. 206). However, the number of key informants and nominees as well as the number of nomination repetitions that led to the final list of potential participants were

not mentioned. Thus, the validity of the results of the purposeful sampling procedure can be questionable.

In another study that investigated coping mechanisms, Schauben and Frazier (1995) explored the relationship between impact of therapeutic work and counselors' personal coping mechanisms. Research participants (N=148) were recruited from an organization of women psychologists and a sexual violence center. Men were excluded due to the few possible male participants. A number of dimensions, including work information, counselor victimization history, psychological functioning (e.g. cognitive schemas, PTSD, vicarious trauma, negative effect, burnout, qualitative data), and coping strategies were examined through open-ended questionnaires, the Traumatic Stress Institute (TSI) Belief Scale (Pearlman & MacIan, 1993), an author-developed PTSD checklist based on the DSMIII-R, Brief Symptom Inventory (BSI, Derogatis, 1977), Maslach Burnout Inventory (MBI; Maslach, Jackson & Leiter, 1996), and Coping Inventory (Carver, Scheier & Weintraub, 1989). Schauben and Frazier found low levels of vicarious symptoms, cognitive disruptions, PTSD, negative effect, and burnout correlated with four major coping strategies: active coping, seeking emotional support, planning and humor. Some specific strategies included "exercise and healthy living, expressing emotions and getting support, and figure out ways to see difficult situation in a more positive light" (p. 62). Using a cognitive strategy by "choosing to look at the positive aspects" of counseling work was a common coping strategy. Some positive aspects therapists chose to look at including counselors' personal growth due to clients' changes, recognition of the contribution to both the individual and societal level as a healer, "creativity, strength, and resilience of survivors", "seeing clients grow and

change", and "being part of the healing process" (p. 62). Further, results of open-ended questions from thirty-five percent of the sample revealed useful stress-reducing coping strategies including: (1) physical and mental health promoting activities (e.g., sleeping, exercise, and diet), (2) spiritual-related activities (e.g., exposure to nature, journaling, and meditating), and (3) leisure activities (e.g., gardening, seeing movies, reading, and listening to music.)

Schauben and Frazier's (1995) study provided evidence for the effectiveness of adaptive coping mechanisms in reaction to negative effects of therapeutic work. However, the high percentage of Caucasian female participants and inclusion of only counselors treating sexual-violence survivors were weaknesses of this study as they limit the study's generalizability.

Awareness seemed to be a significant coping mechanism emphasized by many scholars. For example, Figley (2002b) indicated that awareness of individual and organizational stress is considered to be an efficient self-care strategy that helps the person seek balance between the therapists' personal, professional, physical, emotional, and spiritual needs. Awareness also helps assure therapists' positive attachment with clients. In fact, Kearney and Weininger (2011) suggested that self-awareness is the key element for clinician self-care that alleviates compassion fatigue and burnout. They identified four aspects for clinician awareness to achieve self-care (Kearney & Weininger, 2011, p. 119-121). The four aspects are: (1) self-knowledge, (2) self-empathy, (3) preparing the mind, and (4) contemplative awareness. Self-knowledge refers to the foundation of awareness that involves familiarity and insight regarding personal background (e.g., family of original, history of race, culture, religion, or strength and

weakness). Furthermore, Kearney and Weininger suggested that it is self-knowledge that sustains individuals from challenges of transference and countertransference, as well as helps to maintain more awareness during therapeutic encounters. The aspect of self-empathy, with a foundation of self-knowledge, helps individuals accept their imperfect parts and forgive their own mistakes rather than over-criticizing or punishing themselves. Another aspect is to prepare the mind. To achieve this aspect, three cognitive skills need to be involved: focused awareness, mindful self-awareness, and dual awareness. The first step to prepare the mind is to develop the skill of focused awareness, which is a platform of stabilization and focus of attention in order to facilitate the process of preparing the mind. Kearney and Weininger (2011) indicated that once the status of focused awareness is engaged, mindful self-awareness, the second skill, will be naturally raised, in which physical, emotional and cognitive flows or symptoms will be observed with no efforts. Building on the previous two skills, one can easily reach the final step of dual awareness. Dual awareness is a status in which one can self-monitor internal and external distraction in a non-judgmental way, which prevents individuals from self-preoccupation or depletion. Lastly, the fourth aspect is contemplative awareness, which means psychological recognition of the encounter of personal and professional relationships in the workplace, the family, the community and larger perspectives (e.g. society or universe). Contemplative awareness also includes spiritual recognition of one's values and the meaning of life.

In addition to self-awareness, other suggested coping mechanisms at the individual level included outdoor activities and self-expression (e.g., talking, writing, and creative art) to benefit therapists' emotional health (Hesse, 2002). Assurance of adequate

nutrition, diet, sleep, exercise, and pleasurable hobbies can effectively decrease the effects of vicarious trauma, compassion fatigue, and secondary traumatic stress (Pearlman, 1999). Grosch and Olsen (1994) suggested that therapists contract for supervision with seasoned supervisors outside of the agency because outside supervisors have no evaluation role. An informal peer supervision group can also provide effective mutual supervision. Grosch and Olsen also suggested that therapists have to find balance in their life so as to "taking care of primary relationships, as well as finding time for one's physical, emotional, and spiritual needs (p. 129)."

With regard to coping mechanisms from the organizational level, Sommer and Cox (2005) indicated the importance of a weekly or regular basis of supervision to help cope with vicarious traumatization. In their qualitative study, subjective experiences of supervision among sexual violence counselors (*N*=9, female=8, male =1) from three mid-western states were investigated through a qualitative study. Years of experiences working with sexual violence survivors ranged from 1 to 9. To investigate counselors' subjective experiences of clinical supervision related to vicarious traumatization and how they make meaning of that phenomenon, semi-structured interviews and basic interpretive analysis were employed for this purpose. Results revealed the following four themes associated with helpful clinical supervision (Sommer & Cox, 2005, p. 125-129):

Theme 1. Talking About the Effects of the Work and Addressing Related Personal Feelings

Theme 2. The Importance of Addressing Vicarious Traumatization in Supervision

Theme 3. Helpful Qualities of Supervision

Theme 4. Organizational Considerations

Despite the large proportion of female participants and a wide range of years of clinical experiences that could limit the generalizability of this study, Sommer and Cox's study provided empirical evidence for how quality of supervision and organizational support could help counselors' coping with the negative effects of clinical work.

Coping Mechanisms from both Individual and Organizational Levels. Coping strategies from both personal and organizational levels seemed to be the most recommended by scholars. For example, pertaining to burnout prevention, Maslach (2003a) suggested counselors set realistic goals for workload and client care, have break time and preserve sufficient rest between and after work, and maintain positive relationships in personal life with friends and family members. Maslach (2003b) also pointed out that creating positive and supportive relationships with colleagues and supervisors is a crucial strategy for self-care. Comfort, feedback, humor, viewpoints, insight for difficult cases, or helping with difficult clients or excessive caseloads among co-workers are also beneficial for therapists' self-care.

In Grosch and Olsen's (1994) book *When helping starts to hurt: A new look at burnout among psychotherapists,* they took a systematic perspective looking into therapists' underlying narcissistic vulnerability and family of origin and their relations to therapists' burnout in family and work systems. Grosch and Olsen (1994) emphasized the concept of awareness and assessment in self-care practice from both the personal and organizational level. They identified six steps to recognize the sign of burnout: (1) constant self-assessment, (2) investigation of family of origin, (3) understanding the cohesiveness of the self, (4) utilizing support groups for mental health professionals, (5)

finding effective supervision, and (6) balancing love, work, and play. The step of constant self-assessment suggested counselors constantly assess their personal and professional lives, "distinguish between tiredness, tension, and signs of burnout" (p. 105), "be aware of our own resilience and ability to bounce back from tiredness" (p. 106), and "identify proactive steps that can be taken to prevent burnout" (p. 107). Investigation of the impact of one's family of origin refers to the awareness of how family issues and themes shape their patterns at home and at work. Counselors were encouraged to differentiate professional life from patterns learned from their family of origin. Since narcissistic issues are often found to be a pathological motivation for overwork, the step of understanding one's own narcissistic issues reminds counselors to realistically examine their "fundamental need for appreciation and meaning of deep desire to be liked and admired" (p. 117). Utilizing support groups refers to counselors' usage of professional support groups in order to "deal with the difficulties of self-definition that have been a product of our upbringing, as well as our unmet needs for appreciation" (p. 119). The form of the group may be a general group, a peer supervision group, or a group focusing on family of original issues as long as confidentiality and privacy are secured. Furthermore, counselors were urged to secure effective supervision.

To counteract the negative effects of trauma work on therapists, in their book*, Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors,* Pearlman and Saakvitne (1995) suggested four domains of coping strategies for caring practitioners to prevent secondary traumatization. Domains include: Professional Strategies, Organizational Strategies, Personal Strategies, and General Coping Strategies. *Professional Strategies* refer to counselors' appropriate

maintenance of caseload and usage of supervision; *Organizational Strategies* refer to counselors' ability to maintain break, vacation, and physical space; *Personal Strategies* refer to counselors' realistic expectations, understanding of professional limitations, and active involvement of self-care in leisure time; and *General Coping Strategies* refer to counselors' general ability to restore themselves and maintain connections with supportive resources.

Based on her work as a therapist and supervisor at Menninger Clinic in Kansas, in a book chapter, *Treating the Heroic Treaters,* Cerney (1995) suggested four preventative measures for trauma therapists to pursue personal and professional balance: (1) setting therapeutic realism regarding what kind of patients or diagnoses they feel confident and comfortable treating, (2) seeking on-going supervision and consultation, (3) establishing a balance between personal and professional lives, and (4) maintaining physical and mental health. Furthermore, summarized research literature pertaining to therapists' vicarious trauma, Trippany, Kress, and Wilcoxon (2004) suggested that moderate caseload, peer supervision, professional development resource from organizations (e.g. supervision and consultation), continual education and training, personal coping mechanisms (e.g. social support from significant others, families and friends, creative and physical activities, journal keeping, meditation, etc.), and spirituality were beneficial to therapists' well-bing. Trippany, Kress, and Wilcoxon further emphasized that it is supervisors' responsibility to implement prevention work through "encouraging peer support groups, educating counselors on the impact of client traumas on counselors, diversifying counselor caseloads, encouraging counselor respite and relaxation, and encouraging counselors' sense of spirituality and wellness" (p. 36).

Summary

Although risk-factor oriented studies may not have a central focus on identifying resilience for therapists, the recognition of risk factors, adversity, and challenges that therapists encounter in their daily life certainly deepens our understanding of what resilient therapists have to cope with in their routine work and throughout their professional development. Also, the flip side of risk factors may enrich our understanding and perspective on protective factors for counseling work. Nevertheless, with regard to the purpose of this present study, although both risk-factor and protective-factor oriented studies discussed here may provide remediation or prevention strategies to help assure therapists' well-being, characteristics a therapist needs to be or become a resilient therapist are still opaque.

Other Related Studies

Due to the scarcity of empirical literature directly researching therapist resilience, it was worthwhile to look into risk-factor and protective-factor oriented studies presented in the previous section. Likewise, other related studies that examine therapists' competence, proficiency, professional development, and growth may also provide valuable insights that can broaden and deepen our understanding of resilient therapists.

Therapist Competence and Proficiency

Coster and Schwebel (1997) investigated how therapists maintain well-functioning. In their study, well-functioning was defined as "the enduring quality in an individual's functioning over time and in the face of professional and personal stressors" (p. 5). In the first portion of their study, using the qualitative approach, factors contribute to therapists' well-functioning were investigated. Experienced and well-regarded therapists (*N*=6)

recommended by faculty members were recruited for in-depth interviews. In the second portion of the study, using quantitative methods, attributions of well-functioning among licensed therapists (*N*=339) were investigated through two questionnaires developed by the researchers. Based on the combination of the two studies, researchers concluded that support (e.g., peers, mentors, supervisors, spouses, family, friends) and self-care (e.g., self-awareness, self-monitoring, self-regulation, professional development) were the key factors for therapists to remain a balanced well-functioning life. There is similarity between Coster and Schwebel's findings and what was discussed in the earlier section—risk-factor and protective-factor oriented studies. However, Coster and Schwebel's definition of well-functioning therapists can inform our understanding of resilient therapists.

How about those "best of the best" therapists who are not merely well-functioning but are highly functioning? Beginning from Harrington's (1988) dissertation, Skovholt supervised a series of dissertations exploring characteristics of master therapists (Jennings, 1996; Mullenbach; 2000; Sullivan, 2001). This was at a time when ABPP Board Certification was at the expert level; nowadays, it is at the competent level. In Harrington's (1988) dissertation, psychologists who obtained American Board of Professional Psychology (ABPP) certification were recruited for quantitative investigation. In order to better capture the phenomena of master therapists, three following dissertation projects supervised by Skovholt, between 1995 to 2002, began to use qualitative inquiry as the major research methodology. These three dissertation projects had a similar focus on discovering characteristics of peer nominated master therapists. Ten master therapists were interviewed for an average of six times. A final 90-

minute interview with these three researchers was conducted by Skovholt with an intention of refining the portrait of the highly functioning master therapist. The results are presented in a book chapter in *Master Therapists* (Skovholt & Jennings, 2004). Listed below is the final refinement of four varieties of characteristics (Paradoxical, Identifying, Word, and Central) of master therapists that may best capture and represent this series of master therapist studies. The languages describing the Characteristics are direct quotes from Skovholt, Jennings, and Mullenbach (2004, p. 131-141).

Paradox Characteristics:

- A drive to mastery, yet never a sense of having fully arrived--like traveling on an endless path
- The ability to deeply enter the inner world of another while often preferring solitude
- Providing an emotionally safe environment for a client and yet able to firmly challenge when necessary
- Highly skilled at harnessing the power of therapy to help others while quite humble about oneself
- Thorough integration of the personal and professional selves, yet with clear boundaries between these worlds
- Voracious learner who often directs this energy to broad learning as well as specific work-related topics
- Excellent at giving of self to others while nurturing a private self
- Very open to feedback about oneself yet not personally destabilized by it

Identifying Characteristics:

- High emotional health as evidenced by self-acceptance--shadow, warts, and all
- Understanding of the ambiguous complexity of human nature that precludes an enthusiastic acceptance of any one-dimensional view of human psychology
- Clear rejection of simplified theories and models for use with clients
- Focused motivation to develop self and the ability to be helpful to others
- In a maximum way, used their own life experiences as food for growth
- Deeply confident of the therapy process and their own therapy skills
- Nondefensive acceptance of their own limitations and flaws as evidenced by knowing they are not the best therapists for some clients
- Data from direct work with clients is highly valued
- Drawn to paradoxical, complicated, metaphorical, and profound descriptions of the human condition
- Feeling humility while keeping grandiosity and arrogance at bay
- A wide spirit of empathy from their own reflected and integrated life experiences
- Possession of an internal schema--a wisdom guide--consisting of thick webs of patterns, practices, and procedures developed over many, many hours of work
- A close congruence between personality and demands of the work environment, a "goodness of fit"
- Having the profound ability to respectfully enter the world of another and be of assistance there
- Living for years in a reflective, open style while searching for growth--personal and professional--has produced the Highly Functioning Self

Word Characteristics: Alive, Congruent, Committed, Determined, Intense, Open, Curious, Tolerant, Vital, Reflective, Self-Aware, Generous, Mature, Optimistic, Analytic, Fun, Discerning, Energetic, Robust, Inspiring, Passionate.

Central Characteristics:

- *Domain 1. Cognitive Central Characteristics*: Embraces Complex Ambiguity; Guided Now by Accumulated Wisdom; Insatiably Curious; Profound Understanding of the Human Condition; Voracious Learner.
- *Domain 2. Emotional Central Characteristics:* Deep Acceptance of Self; Genuinely Humble; High Self-Awareness; Intense Will to Grow; Passionately Enjoys Life; Quietly Strong; Vibrantly Alive.
- *Domain 3. Relationship Central Characteristics*: Able to Intensively Engage Others; Acute Interpersonal Perception; Nuanced Ethical Compass; Piloted by Boundaried Generosity; Relational Acumen; Welcomed Openness to Life Feedback.

(Skovholt, Jennings, & Mullenbach, 2004, p. 131-144)

Some limitations of these studies need to be considered. Repeated interviews of the 10 participants may reduce the validity and create biased results. All participants were Caucasians and all were from the Minneapolis-St. Paul area, these factors also limited these studies. On the other hand, wisdom refined from three studies and 6000 hours of research provided rich data for the study of master therapists. This also enriched our research line of resilient therapists. For example, although it is unknown whether resilience or expertise comes first in a counselor's professional life, characteristics of highly functioning counselors definitely provide additional aspects (e.g., emotion,

cognition, or relationships) for our understanding of resilient counselors' characteristics.

The study of master therapists was later expanded within the cross-cultural context. So far, characteristics of master therapists have been explored in South Korea (Kwon & Kim, 2007), Singapore (Jennings et al., 2008), Canada (Smith, 2008), and Japan (Hirai, 2010). The Singapore study (Jennings et al., 2008) also provided a comparison with the U.S. study (Jennings & Skovholt, 1999). These studies have enriched our understanding of resilient therapists from a cross-cultural perspective.

In the Singapore study (Jennings et al., 2008), nine peer-nominated Singaporean master therapists (male=5, female=4) were interviewed in a cross-national study. Specifically, participants' personal characteristics, developmental influences, and therapy practices were examined. The age of participants ranged from 40 to 59 years old; years of clinical experienced ranged from 10 to 34 years. The diversity of participants varied in racial, educational, and credential backgrounds, as well as theoretical orientations. Grounded theory procedures (Strauss & Corbin, 1998) and analytic procedures adopted from consensual qualitative research (Hill et al., 2005), following with a cross-case analysis (Patton, 2002) were conducted to analyze data collected from eighteen open-ended interview questions. Four categories and sixteen themes emerged. They are (Jennings et al., 2008, p. 511-515):

Category A. Personal Characteristics. Three themes were included: empathic, nonjudgmental, and respectful.

Category B. Developmental Influences. Four themes were included: experience, self-awareness, humility, and self-doubt.

Category C. Approach to Practice. Six themes were included: balance between

support and challenge, flexible therapeutic stance, empowerment/strength-based approach, primacy of the therapeutic alliance, comfortable addressing spirituality, and embraces working within a multicultural context.

Category D. Ongoing Professional Growth. Three themes were included: professional development practices, benefits of teaching/training others, and challenges to professional development in Singapore.

Researchers further conducted a qualitative meta-analysis in order to compare results between this study and a previous similar study that used U.S. samples (Jennings & Skovholt, 1999). Twelve out of twenty-five themes between the two studies were found strongly related. These twelve related themes, centered on the therapeutic relationship, the alliance, and therapists' experiences, suggested expert therapists' universal characteristics across differ nations. It is noteworthy that the following four themes of this study were found divergently from the U.S. study: (1) challenges to professional development, (2) embraces working within a multicultural context, (3) comfortable addressing spirituality, and (4) self-doubt (Jennings et al., 2008, p. 519). Authors noted that the last three divergent themes might be significant multicultural elements for the study of master therapists.

This study not only initiated the master therapists study in Singapore but also contributed a cross-cultural perspective to the master therapist studies that have been conducted in the U.S. Particularly, cross-cultural elements found in this study that are different from the U.S. study provided a different perspective for the master therapist studies. However, some limitations of this study needed to be considered. For example,

using the same definition as the U.S. study might be questionable when applying to Singapore. Also, possible biases might exist when adopting similar research content and procedures from the previous U. S. study, especially when major researchers were the same from the previous study.

Also, to deepen the understanding of multicultural elements found in the previous study (Jennings et al., 2008), a follow-up qualitative study (Jennings et al., 2012) is worth noting. In the 2012 study, 6 out of 9 Singaporean master therapists (male=3, female=3) from the 2008 study were recruited. To understand these therapists' conceptualization and conduction of cross-cultural counseling was the aim of this follow-up study. Through twelve open-ended questions and using the same data analysis procedures from the previous study, two categories and eight themes were yielded (Jennings et al. 2012, p. 138-140):

Category A. Multicultural Knowledge, including four themes: Self-Knowledge, Cultural Immersion, Cultural Knowledge, and Knowledge of Systematic/Historic Oppression.

Category B. Multicultural Skills, including four themes: Respect, Cultural Misunderstandings Lead to Humility and Growth, Ask (Don't Assume), Suspended Judgment and Avoid Imposing Values.

This study contributed to our further understanding of multicultural elements among Singaporean master therapists' counseling process. However, the similar research limitations remain the same as those in the previous study. Also, repeated interviews of the same participants as the previous study also may reduce the validity of the results.

Therapist Development and Depletion

With an interest in understanding psychotherapists' development, Orlinsky, Rønnestad, and the Collaborative Research Network (2005) assembled a database of psychotherapists (*N*=5000) world-wide over a span of fifteen years. They created the Development of Psychotherapists Common Core Questionnaire (DPCCQ), a 392-item instrument, and conducted multiple sample procedures, and systematic, qualitative analysis. Through a number of research questions—"How does development influence their [psychotherapists'] work and their personal and professional lives?" "To what extent are there patterns of professional development and to what extent do they differ by profession, nationality, theoretical orientation, etc.?" "How and to what extent do psychotherapists develop over the course of their careers?" and "What professional and personal circumstances positively or negatively impact development?" (p. 7) —Orlinsky et al. (2005) intended to understand psychotherapists' vocational choices, changes over time, and the daily problem they experienced.

Results of Orlinsky et al. (2005) study showed both positive and negative catalysts for therapists' therapeutic work and were presented based on three broad strands of involvement: *Healing Involvement*, *Stressful Involvement*, and *Controlling Involvement*. Due to the reliability of the results, the first two involvements were the major focus of the study. *Healing Involvement* refers to "therapists' affirming and attending manner in relating to patients, his or her sense of being invested and efficacious instrumentally, as having current skillfulness, generating flow feelings in therapy sessions, and meeting any difficulties that arise with constructive coping" (p. 82). In contrast, *Stressful Involvement* refers to "therapists' experiences of low current skillfulness, high

total difficulties, avoiding therapeutic engagement in the face of difficulties, and tending to feeling anxiety and boredom during therapy sessions" (p. 82).

According to the interactions between high and low levels of Healing Involvement and high and low levels of Stress Involvement, together, the researchers identified four practice patterns: *Effective Practice, Challenge Practice, Disengaged Practice, and Distressing Practice*. *Effective Practice* refers to therapeutic work associating with much Healing Involvement and little Stressful Involvement; *Challenge Practice* refers to much Healing Involvement and more than a little Stressful Involvement; *Disengaged Practice* refers to not much Healing Involvement but also little Stressful Involvement; and, *Distressing Practice* refers to more than a little Stressful Involvement and not much Healing Involvement. Results showed 50% of the Western therapists reported a pattern of Effective Practice; 10 % of the Western therapists reported a pattern of Distressing Practice, which indicated a practice pattern of more than a little Stressful Involvement and not much Healing Involvement.

With regard to counselor development, Orlinsky et al. (2005) used the term "currently experienced development"(p. 106) to describe current and continual transformation processes of both improvement or impairment. Through a further factor analysis, researchers indicated two dimensions of the development among research participants: *(1) Currently Experienced Growth* and *(2) Currently Experienced Depletion*. The dimension of Currently Experienced Growth was defined by six positive questions: "becoming more skillful, deepening understanding of therapy, overcoming limitations as a therapist, current change as progress/improvement, currently changing as a therapist, and experience sense of enthusiasm" (p. 110). On the other hand, four negative questions

related to the dimension of Currently Experienced Depletion: "performance becoming routine, losing capacity to respond empathically, becoming disillusioned about therapy, and sense of current decline/impairment" (p. 110). Results showed a strong bivariate correlation between therapists' experience of Healing Involvement and Currently Experienced Growth. Not surprisingly, therapists' experience of Stressful Involvement was found to correlate strongly with Currently Experienced Depletion.

Although this study has an extremely big sample across different nations, solely relying on self-reported measurement through opened-ended survey questions limits the validity of this study. Participants' individual and cross-national differences may also weaken the study. However, with 15 years of data collection from a N=5000 international sample, this study contributes significantly to the database and research on counselor development.

In addition, based on years of extensive research on counselor development, the following Ten Themes of Therapists' Professional Development proposed by Rønnestad and Skovholt (2013) are also valuable for our understanding of resilient therapists from the perspective of therapist and counselor development:

Theme 1: Optimal Professional Development Involves an Integration of the Personal Self into a Coherent Professional Self

Theme 2: The Modes of Therapist/Counselor Functioning Shifts Markedly Over Time—From Internal to External to Internal

Theme 3: Continuous Reflection Is a Prerequisite for Optimal Learning and Professional Development at All Levels of Experience

Theme 4: Professional Development Is a Lifelong Process

Theme 5: Professional Development Is mostly a Continuous Process but can also be Intermittent and Cyclical

Theme 6: An Intense Commitment to Learn Propels the Developmental Process

Theme 7: Many Beginning Practitioners Experience Much Anxiety in Their Professional Work: But Over Time, Anxiety is Mastered by Most

Theme 8: Interpersonal Sources of Influence Propel Professional Development More Than "Impersonal" Sources of Influence

Theme 9: Not All Therapists/Counselors Develop Optimally

Theme 10: There Is a Realignment from Self as Powerful to Client as Powerful

(Rønnestad & Skovholt, 2013, p. 145-159)

It is important to note that, in Theme 9, researchers indicated several personal characteristics significantly related to therapists' continually optimal development. They are "intelligence," "brightness," "a capacity for empathy," "emotional control," and "patience" (p. 158). These characteristics that sustain therapists' on-going optimal development may parallel characteristics that retain therapists' resilience.

Summary and Conclusion

There are similarities between studies on therapist resilience, risk-factors, and protective-factors studies, and other related studies focusing on therapists' competence, proficiency, development and depletion. All these studies tend to explore stressors, challenges, and risks while inquiring about protective factors in therapists' work. For example, the correlation found between therapists' Stressful Involvement and Currently Experienced Depletion (Orlinsky et al., 2005) seemed to connect to those findings in the risk-factor oriented studies; and, the Healing Involvement and Effective Practice seemed

closely connected to findings in protective-factor oriented studies. How does this similarity inform us with regard to the study of highly resilient therapists? The similarity of recognizing risk factors in counseling work validates the contribution of pathological-centered studies and how they may benefit our understanding of resilient-oriented studies. Also, both risk and protective factors needed to be taken into consideration during the exploration of resilient therapists. Further, with regard to well/highly functioning master therapists, if becoming a highly functioning master therapist is a desired process in therapist development, positive characteristics found in highly functioning master therapist studies may somewhat inform our understanding of characteristics essential for becoming a resilient therapist.

Pertaining to the focus of the present study on highly resilient therapists, some questions are worthwhile when considering the implications of the literature reviewed here. For instance, in the highly functioning master therapist studies (Skovholt & Jennings, 2004), "Do these positive characteristics among master therapists come internally or can they be learned?" and "How much overlaps exist between characteristics of highly functioning master therapists and highly resilient therapists?" In addition, when multicultural elements were considered in the study of highly resilient therapists, "How does multicultural competence play a role for resilient therapists?" More specifically, "Is it possible that multicultural competence serves as a protective factor for resilient therapists?" Furthermore, "Does the term *resilient therapists* mean the same thing in different cultures?"

With regard to the specific research questions of the present study—characteristics, force/energy/source, and a definition of highly resilient therapists—a few

empirical studies that directly investigated therapists' resilience seem to offer useful insights. Thus far, characteristics and force/energy/source identified in the literature include: the internal resources among midlife lesbian white psychologists (Lidderdale, 2009) such as "passion," "an inner sense," and "value of an inner life as important" (p. 182); "hope" and "optimism" (p. 263) for social workers (Collins, 2007); Paradox Characteristics, Identifying Characteristics, Word Characteristics, and Central Characteristics among U.S. master therapists (Skovholt & Jennings, 2004); personal characteristics among Singapore master therapists (Jennings et al., 2008) such as "empathic," "nonjudgmental," and "respectful" (p. 512); and, "intelligence," "brightness," "a capacity for empathy," "emotional control," and "patience" (p. 158) for therapists' continual optimal development (Rønnestad & Skovholt, 2013). These identified characteristics and force/energy/source provide rich information for this present study of resilient therapists. However, they also remind us of the need for the exploration of characteristics and force/energy/source specifically among highly resilient therapists.

Also, while research on the resilience-side of therapists is growing, a suitable definition specific for *highly resilient therapists* remains ambiguous. Even if studies have directly used the term *resilience* in studying therapists' well-being, a tendency is to adopt definitions of resilience from research that is based on at-risk children, adolescents, or trauma-related clients. Mullenbach's (2011) definition of professional resiliency for master therapists seems to be the only authentic definition for therapists. Collins' (2007) definition for adults and social workers is another one that is close to our study on resilient therapists. In conclusion, the field of the mental health professions will benefit

from more detailed and specific studies that address essential characteristics and force/energy/source for therapists to remain, sustain, or nurture resilience. Moreover, a suitable definition of the *highly resilient therapist* that is specifically tailored for the complex work of counseling is needed.

Chapter Three

Methodology

Introduction

The present study uses qualitative methodology. Considering a relative paucity of research on therapist resilience, "qualitative methods can be used to explore variables that are not easily identifiable or that have not yet been identified, as well as investigating topics for which there is little or no previous research and addressing contradictions in literature that arise from prematurely, inaccurately, or inadequately operationalized variables" (Morrow, 2007, p. 211). The rationale for using qualitative inquiry lies with the fact that "Qualitative methods facilitate study of issues in depth and detail. Approaching field work without being constrained by predetermined categories of analysis contributes to the depth, openness, and detail of qualitative inquiry" (Patton, 2002, p. 14). Qualitative inquiry is especially suitable for the present study because this study has centered on questions of "How?" and "What?" instead of "Why?" (Creswell, 1998). Furthermore, due to little understanding of therapist resilience in the mental health professions, methods could enhance our understandings of therapist resilience through "examining individual perspectives in contexts" (Heppner et al., 1999, p. 235). Specifically, through qualitative inquiry, the complexity of phenomena such as individuals' (therapists') thought processes and feelings (Straus & Corbin, 1998) can be well described and clarified "as it is lived and constituted in awareness" (Polkinghorne, 2005, p. 138).

Participants

For this present study, highly resilient therapists were identified through two

levels of sample screening—the peer nomination procedure and two survey scales. Namely, exemplars identified as highly resilient therapists in this study are individuals who (1) received a minimum of nominations that met the cut-off points for minimum nominations, and (2) obtained high scores on two survey scales.

The First-Level Sample Screening: Peer Nomination

Patton (2002) suggested that "studying information-rich cases yields insights and in-depth understanding rather than empirical generalizations" (p. 230). For the first-level sample screening, in order to ensure only information-rich cases were selected to exemplify highly resilient therapists, a qualitative method—peer nomination procedure (Patton, 2002)—was conducted by the primary researcher.

Key informants. To identify potential key informants, the researcher consulted his advisor, dissertation committee members, and experienced researchers in the study of master therapists that also used peer nomination methods (Jennings & Skovholt, 2009). Ten key informants were identified based on practitioners who have (1) active involvement in clinical work over a long period of time, (2) a strong reputation for being well-regarded, well-situated, and well-connected mental health practitioners, and (3) a diverse background as a group. Furthermore, according to Patton (2002), "the chain of recommended informants would typically diverge initially as many possible resources are recommended, then converge as a few key names get mentioned over and over" (p. 237). Thus, for criteria (3), a diverse background as a group, key informants identified in this study were considered diverse in terms of practice settings, gender, disciplines (e.g. counseling psychology, clinical psychology, social work, marriage and family counseling, and psychiatry, etc.), racial/ethnic backgrounds, and training programs they graduated

from. For example, an effort was made to avoid only recruiting key informants who were trained from the same doctoral program of the researcher of this dissertation.

Upon approval from the University of Minnesota Institutional Review Board in May 2014, the researcher began to contact ten key informants. In the invitation email (see Appendix A), the purpose, methods, and procedure of this study were delineated. Each key informant was asked to nominate up to three people who meet the following inclusion criteria: (a) this person was trained in a mental health field at the master's or doctoral level, (b) this person has been actively working with clients full or part time for a minimum of ten years, and (c) the key informant will describe the person nominated to be a resilient therapist. Key informants were asked to provide an email address for each nominee. For criteria (c), key informants were given a definition of a highly resilient therapist, which was derived from a number of sources (Rønnestad & Skovholt, 2013; Richardson et al., 1990; Skovholt, 2001, 2005, 2012) and in consultation between the researcher and his adviser. The definition of highly resilient therapists is as follows:

> While working as a therapist over many years, a highly resilient therapist is effective as a therapist with their clients and is able to be fully engaged with client after client. Over time, a highly resilient therapist is able to continually bounce back from discouraging and disruptive aspects of clinical work. The highly resilient therapist is also able to develop recurrent professional optimism and vitality, as well as experience on-going professional growth.

Up to three follow-up reminder emails were sent to ten key informants to encourage their participation in the nomination process. Consequently, all key informants responded

to the primary researcher. One of these key informants gently declined to participate in the nomination process due to demanding work (see Table 3.1).

Nominees. Using email addresses of nominees provided by the key informants, the researcher then continued the peer nomination process by sending the invitation emails (see Appendix B) to those who have been nominated. Each person nominated was then asked to follow the same procedure as the key informants. The following procedure was employed in order to ensure nominated therapists were reached: after the initial invitation email, two follow-up reminder emails were sent if nominees had not responded. For nominees who did not respond to initial invitation emails and two follow-up reminder emails, via internet, the researcher located these nominees' office phone number and address. Phone calls or phone messages along with a third reminder email were sent. Further, a hardcopy of the invitation letter, send via U.S. Postal Services (USPS) regular mail to those who did not respond, was signed by both the primary researcher and his adviser. A returning nomination card and a returning envelop were enclosed with the written letter. In the circumstance when nominees did not know his or her nominees' email addresses or did not feel comfortable to provide email addresses, the primary researcher located these nominees' contact information via the internet. When nominees' office phone numbers and office addresses were the only information accessible via the internet, two phone calls (or phone messages) were made by the primary research as well as a hardcopy of invitation letter with an returning envelop and a nomination card sent via USPS regular mail. After these attempts, no future action was taken to engage nominees' participation.

To increase a diverse research sample, extra time and effort was made to contact

certain nominees. These were diverse by ethnicity and degree: one Native American, three African Americans nominees, and one psychiatrist (M.D.). Nevertheless, only the psychiatrist and the Native American nominees responded and participated in the nomination process. In addition, one deaf psychologist, who mainly works with the deaf and deaf/blind community, expressed her difficulty in thinking of potential nominees in the deaf community, excepting one social worker locating in a different state. She did not nominate anymore.

In order to ensure the validity of the nomination process, in three situations when a nominator nominated more therapists than the three nominations requested, they were asked to select only three. If they did not respond and select three, the first three nominees, indicated in their nomination list, were chosen.

Exceptions were made for three nominees regarding their nomination of others. One had only eight years (instead of ten) of clinical experience and two nominees recently retired (instead of currently practicing). After consulting with the primary researcher's advisor, who has extensive research on counselor development, an exception was made for these three nominees. Their nominations of others were therefore included in the peer nomination process.

Beginning in May 2014, the peer nomination process lasted for eight weeks and went through 8 total rounds. The primary researcher spent approximately 214 hours in completing this process. The nomination process was ceased for a number of reasons. First, more therapists were repeatedly nominated and fewer new names emerged. For example, by the end of the sixth week, more than 50 therapists were nominated twice, and 14 therapists were nominated three times or more. The peer nomination process

slowed down and fewer invitations needed to be sent. Secondly, adequate numbers of nominees reached the cutoff point of the minimum nominations needed for entering the second phase of the sample screening. In consultation with the researcher' advisor and committee members, an ideal research sample for this study was to recruit 8 to 10 participants. Also, in consultation with the existing literature (see below), the researcher and his advisor determined three nominations as the nature breakpoint for entering the second-level sample screening.

When a therapist received a minimum of three nominations, he or she was eligible to participate in the second phase of the sample screening. Since an adequate number of nominees met the cutoff point, the researcher and his advisor decided to cease the first-phase sample screening and start the next phase of sample screening. This rationale for concluding the peer nomination process was made based on a sampling method procedure noted by Skovholt and Jennings (2004). In their 2004 master therapist research, it took eight repetitions of the nomination procedure to reach a point of redundancy/saturation. From a total nomination sample of 103, Skovholt and Jennings chose a minimum of four nominations to be the cutoff point in order to ensure an adequate balance between breath and the depth of the sample size (N=10). In addition, Patton (2002) suggested that the appropriate time to cease the nomination process is when certain names reoccur again and again while fewer names emerge. In the present study, the purpose of the peer nomination was to identify therapists who were perceived by others as highly resilient therapists. Since two survey scales in the second-level sample screening were used to validate the quality of the exemplars, the primary researcher and his advisor decided that three nominations was justified to be the cutoff

point for entering the second-level sample screening.

Outcomes of the first phase. The peer nomination process was ended at the eighth repetition (see Tables 3.1, 3.2, & Figure 3.1). By the time the process was concluded, a total of 201 different therapists were nominated. Of the 201 different nominees, 102 responded to the primary researcher and participated in nominations. With regard to multiple nominations, of the 201 different nominees, 130 therapists received one nomination (64.68%), 51 therapists received two nominations (25.37%), 14 therapists received three nominations (6.97%), five therapists receive four nominations (2.49%), and one therapist received six nominations (0.5%). Namely, 20 of the 201 nominees received three or more nominations (9.95%), and 181 nominees received one or two nominations (90.05%). As a result, a total of 20 nominees met the minimum nominations required for entering the second-level sample screening. Their number of nominations ranged between three and six (*M=3.4*).

Table 3.1
Response Results of the Peer Nomination Process

	Key Informants (*n*)	Nominees (*n*)								
		Repetition of Nomination Process								
		1	2	3	4	5	6	7	8	Total
Nominees	10	25	37	49	33	23	15	10	9	201
Responded and participated in nomination	9	16	25	26	15	10	6	4	0	102
Respond but declined to participate in nomination	1	2	1	4	1	0	0	0	0	8
No responses or was contacted	0	7	11	19	17	13	9	6	9	91
Repeated nominees	-	0	5	23	32	17	13	7	2	99
Response rate (%)	90	72	70.27	61.22	48.48	43.48	40	40	0	54.73

Figure 3.1
Illustration of the Nomination Process

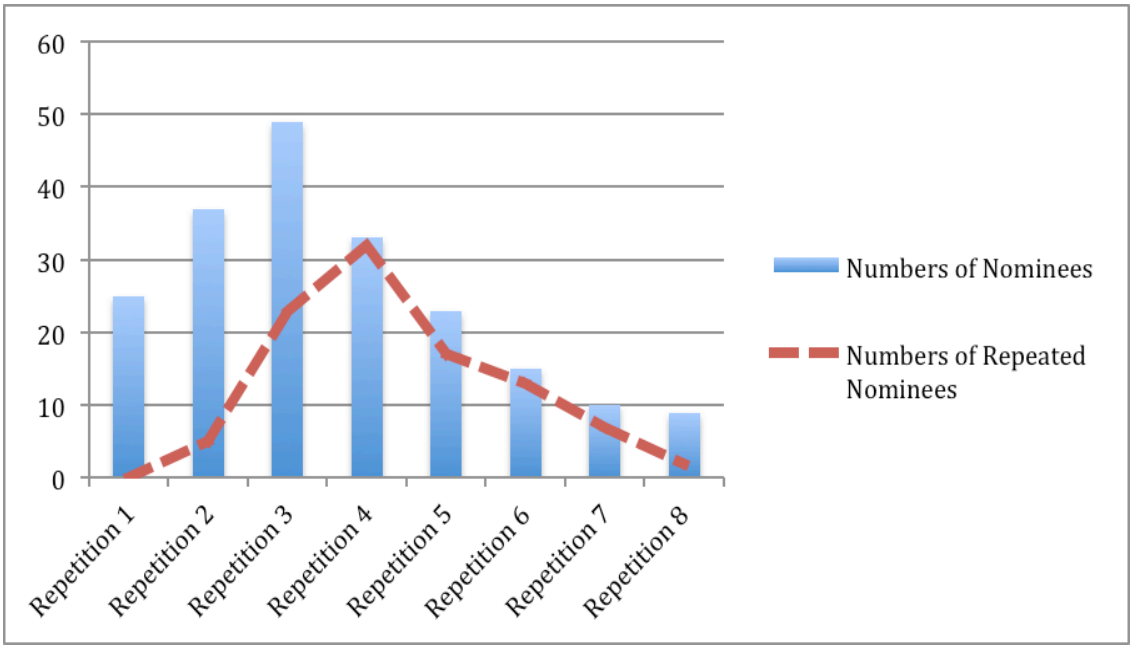


Table 3.2
R*esults of Multiple Nominations (N=201)*

	Numbers of Nominations (votes)				
	1	2	3	4	6
Nominees (n)	130	51	14	5	1
Nominees (%)	64.68	25.37	6.97	2.49	0.5

The Second-Level Sample Screening: Two Scales

The peer nomination procedure for the first-level screening was mainly based on the perception of others. To increase the validity of the study and to ensure only precisely information-rich cases would be studied, a self-reported survey consists of two quantitative measurements was employed. Namely, the second-level sample screening aimed at ensuring participants recruited for this study were also self-perceived and self-identified as highly resilient therapists.

Of the 20 eligible nominees who reached the cutoff point of three minimum nominations, all eligible nominees were subsequently invited to participate in the second-level sample screening (see Appendix C); one declined to continue. Via a confidential online survey, these 19 nominees were asked to complete two quantitative measurements: (1) Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003), and (2) Professional Quality of Life Scale Version 5: Compassion Satisfaction Subscale (ProQOL 5; Stamm, 2009).

Nominees who completed the online survey were sent a confidential email indicating their survey results. Two informational web links pertaining to the CD-RISC and the Pro-QOL 5 were also provided for their reference (see Appendix D). Nominees who scored high on both scales (i.e. self-perceived as highly resilient) were considered to be an eligible exemplar of the highly resilient therapist for this study. To be considered *highly* resilient for this study, individuals needed to obtain a sum score above 93.2 on the CD-RISC, that is one standard deviation above the general population mean, and obtain a sum score that reaches the *high* level (sum scores > 42) on the compassion satisfaction subscale of the Pro-QOL 5. See the instrument section for details.

Outcomes of the second phase. Of the 19 eligible nominees, 18 responded and filled out the online survey (94.7%). The scores of these 18 respondents' CD-RISC ranged between 94 and 121, with an average score of 105.8. The score of compassion satisfaction subscale of the Pro-QOL 5 ranged between 40 and 50, with an average score of 45. The results showed overall high compassion satisfaction and resilience among these 18 nominees. Based on the criteria for determining a highly resilient therapist in this study—a sum score of CD-RISC above 93.2, and a sum score of Compassion Satisfaction subscale above 42—17 out of 18 nominees obtained both sum scores that reached the *high* level in both scales. Thus, a total of 17 nominees were eligible as highly resilient therapists and were considered potential participants for this study.

The goal of the present study was to recruit 8 to 10 participants for in-depth interviews. In consultation with the primary researcher's adviser, of the 17 potential participants, 13 were first invited to participate in the study. The remaining 4 potential participants were to be contacted only when the numbers of recruited participants were insufficient. The rationale for selecting the first 13 potential participants out of 17 was based on an effort to maintain a diversity of research sample. To ensure the diversity of disciplinary backgrounds, these 17 potential participants were first divided into three groups according to their professional discipline/credential. As a result, three potential participants were licensed marriage and family therapists (LMFT), 3 were licensed independent clinical social workers (LICSW), and 11 were licensed psychologists (LP). As a result, the 3 LMFT and 3 LICSW were included on the invitation list. With regard to the 11 LPs, the following four criteria were used to select 7 out of 11: (1) numbers of nominations, (2) gender, (3) racial/ethnic background, and (4) practice setting. In

consultation with the primary researcher's adviser, exact scores of the two self-reported online scales were not included in the criteria for determining the invitation list of research participants in that the self-reported inventories were used only for cut-off points.

Consequently, the first 13 potential participants were sent an invitation email (see Appendix E) that consisted of (1) an explanation of the purpose and the procedure of the interview, and (2) a confidential web-link to an online informed consent (Appendix F) and demographic form (Appendix G). Of the 13 potential participants who were invited to participate in the in-depth interview, 1 LISCW and 1 LMFT did not responded to the invitation after one invitation email, two follow-up reminder emails, and one phone message made by this primary researcher and his adviser. One LISCW declined to continue. The researcher chose to respectfully cease attempts to contact these 3 potential participants. As a result, 10 out of the 13 potential participants agreed to participate in the in-depth interviews. Therefore, the sample recruitment procedures were terminated because an adequate number of eligible research participants were recruited.

Sample Characteristics

For the first phase sample screening, 10 key informants were identified in consultation with the primary researcher's advisor and dissertation committee members. To ensure that key informants were diverse as a group, of the 10 key informants, 5 were males and 5 were females. With regard to the race/ethnicity, 1 was African American, 1 was Latina, 1 was bi-racial (East Asian and White), and 7 were White. In terms of disciplines, 7 of them were doctoral level licensed psychologists, 1 was a doctoral level licensed marriage and family therapist, and 1 was a doctoral level licensed social worker. In terms of practice settings, 3 of them worked in college counseling centers, 1 worked in

both a community clinic and a private practice, 3 worked in the community clinic, 1 worked in the private practice, 1 was a professor in the field of social work, and 1 was a professor in the field of family counseling. It is important to note that for the present study, the purpose of conducting a two-level sample screening was to select eligible participants. Thus, the demographic information of key informants, nominees, and survey respondents was not collected in either phase of the sample screening and cannot to be provided.

After 10 participants were identified and agreed to participate in the study for the in-person interview, their demographic information was obtained. However, for these 10 interviewed research participants, only some demographic information was requested and provided in the study in the effort to protect anonymity and privacy of participants. Demographic information for these 10 interviewed participants is presented as follows (also see Table 3.3 for a summary): Of the 10 participants, 9 participants identified as female (90%) and 1 identified as male (10%); age ranged from 41 to 70 years old. Seven participants (70%) held a doctoral level degree (Ph.D. or Psy.D.) in psychology; all were LP licensed. The other 3 participants held master-level degrees (MS, MSE, or MSW), 2 have a LMFT license (20%) and 1 has a LICSW license (10%). Nine participants identified as White/Caucasian (90%) and 1 identified as Native American (10%). Three participants (30%) had 11-15 years of post-degree clinical experiences, 1 had 16-20 year (10%), and 6 had more than 20 years of experience (60%). With regard to practice setting, 1 practiced at a college counseling center (10%), 5 were in private practice (50%), 2 were in community clinic (outpatient/day treatment) (20%), and 1 identified as working in both a community clinic (outpatient/day treatment) and a private practice (10%). The range of

participants' weekly direct client contact hours varied from 1-10 to more than 40 hours per week. Of the 10 participants, 6 identified as having no particular association with any religion or spirituality (60%), 2 identified as having a religious preference in Christianity (20%), 1 in Buddhism (10%), and 1 in Native American Spirituality (10%).

Clinical Impressions of Participants' Interview Behavior

All participants appear to be eager to meet and openly share their personal experiences. Most participants felt surprise to have been considered as highly resilient therapists yet felt honored and humbled to have been nominated and invited to participate in this study. All participants answered all questions, except one who did not have a metaphor for highly resilient therapists. Two participants reported the interview questions being "difficult" yet "interesting." One participant reported gaining deeper understanding through the process of the interview about attributions for being resilient. All participants showed passion and authenticity by expressing true emotions associated with challenging personal experiences especially after interview question 2 which had facilitated a deeper level of personal conversations.

Table 3.3
Participant Demographic Information (*N=10*)

Participant	Sex/Gender	Range of Age	Credential	Race/Ethnicity	Range of Experience (years)	Setting	Range of Weekly Direct Client Hours	Religion/ Spirituality
1	Female	41-50	LP/PsyD	White	> 20	University Counseling Center	11-20	None
2	Female	61-70	LP/PsyD	American Indian	> 20	Private Practice and Community Clinic	31-40	Native American Spirituality
3	Male	51-60	LP/PhD	White	> 20	Private Practice	> 40	None
4	Female	41-50	LMFT/MSE	White	16-20	Private Practice	21-30	Christianity
5	Female	61-70	LMFT/MS	White	> 20	Private Practice	1-10	Buddhism
6	Female	51-60	LICSW/MSW	White	> 20	Community Clinic	31-40	None
7	Female	61-70	LP/PhD	White	> 20	Private Practice	21-30	None
8	Female	41-50	LP/PhD	White	11-15	Private Practice	11-20	Christianity
9	Female	41-50	LP/PhD	White	11-15	Private Practice	11-20	None
10	Female	41-50	LP/PhD	White	11-15	Community Clinic	31-40	None

Note. To ensure the privacy of participants, the order of participants does not follow criteria (i.e. numbers of nomination) for sample selections.

Instruments

The Connor-Davidson Resilience Scale (CD-RISC). CD-RISC was developed by Connor and Davidson in 2003. Using a 5-point Likert scale (0 = not at all; 4 = true nearly all the time), the original CD-RISC contains 25 self-rated items with the purpose to measure and quantify resilience for the general population as well as to assess treatment responses for clinical populations. Within the total score range between 0 to 100, higher scores represents greater resilience. Several sources (Kobasa, 1979; Lyons, 1991; Rutter, 1985) comprise the content of the CD-RISC that reflects features of resilience. Despite that the CD-RISC is not specifically designed for assessing practitioners' work, its features on examining participants' resilient characteristics strengthen our sample screening procedure and ensure only exemplary cases were recruited. These features of resilience listed in Connor and Davison (2003) are quoted as follows:

1) Able to adapt to change
2) Close and secure relationships
3) Sometimes fate or God can help
4) Can deal with whatever comes
5) Past success gives confidence for new challenges
6) See the humorous side of things
7) Coping with stress strengthens
8) Tend to bounce back after illness or hardship
9) Things happen for a reason
10) Best effort no matter what
11) You can achieve your goals

12) When things look hopeless, I don't give up

13) Know where to turn for help

14) Under pressure, focus and think clearly

15) Prefer to take the lead in problem solving

16) Not easily discouraged by failure

17) Think of self as strong person

18) Make unpopular or difficult decisions

19) Can handle unpleasant feelings

20) Have to act on a hunch

21) Strong sense of purpose

22) In control of your life

23) I like challenges

24) You work to attain your goals

25) Pride in your achievements

(Connor & Davidson, 2003, p. 78)

Connor and Davidson (2003) reported good internal consistency among nonclinical populations with a Cronbach's alpha coefficient of 0.89, as well as a good test-retest reliability among a clinical sample with an intra-class coefficient of 0.87. Connor and Davidson also reported mean score in each tested population: general population (*M*=80.4; *SD*=12.8), primary care outpatients (*M*=71.8; *SD*=18.4), psychiatric outpatients (*M*=68.0; *SD*=15.3), patients with generalized anxiety disorder (*M*=47.8; *SD*=19.5), patients with PTSD (*M*=52.8; *SD*=20.4). Good construct validity of the CD-RISC was consistently demonstrated by several published studies (Karairmak, 2010;

Lamond et al., 2008; Connor & Zhang, 2006). For the present study, potential participants who scored one standard deviation above the general population mean (sum score > 93.2) were considered to be highly resilient.

Professional Quality of Life Scale (Pro-QOL 5): Compassion Satisfaction Subscale. The Pro-QOL 5 (Stamm, 2009) is a 30-item self-rated inventory that uses 5-point Liker scale (1 = never; 5 = very often) to assess helpers' perceptions of their professional quality of life. The Pro-QOL 5 consists of three subscales to examine both the positive aspect (Compassion Satisfaction Subscale) and negative aspects (Burnout and Secondary Traumatic Stress) of helpers experience sufferings and traumas. According to Stamm (2010), compassion satisfaction is the pleasure helpers experience when they are able to do well in their work, including the aspects of helping clients effectively, maintaining positive relationships with colleagues, or contributing to the workplace or the greater society. On the other hand, burnout, which is considered the same as compassion fatigue, is the feelings of hopelessness when helpers experience difficulty and ineffectiveness at work. Stamm (2010) referred to Secondary Traumatic Stress (STS) as the negative effect of caring when helpers are exposed to clients' extremely traumatic events and then experience STS symptoms. STS is considered an element of compassion fatigue. In addition to the non-diagnostic purpose of the Pro-QOL 5, the compassion satisfaction subscale of Pro-QOL 5 was particularly chosen for our sample screening because it features the positive aspects of practitioners' work, which fits well with this resilient-oriented study. Ten items that feature positive characteristics of Compassion Satisfaction in Pro-QOL 5 (Stamm, 2009) are as follows:

1. I get satisfaction from being able to *[help]* people.

2. I feel invigorated after working with those I *[help]*.
3. I like my work as a *[helper]*.
4. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
5. My work makes me feel satisfied.
6. I have happy thoughts and feelings about those I *[help]* and how I could help them.
7. I believe I can make a difference through my work.
8. I am proud of what I can do to *[help]*.
9. I have thoughts that I am a "success' as a *[helper]*.
10. I am happy that I chose to do this work.

Stamm (2010) reported that Pro-QOL 5 has good construct validity based on consistent findings in over two hundred peer-reviewed papers. The tested mean score (t score) of the Compassion Satisfaction Subscale is 50 (*SD*=10), equals sum scores between 23 and 41. The alpha scale reliability is .88. Approximately, 25% of individuals obtains t scores higher than 57 (sum scores ≥ 42), and 25% of individuals obtains t scores lower than 43 (sum scores ≤ 22). Individuals who obtain mean t scores equal to or above 57 (sum scores ≥ 42) indicate a high level of compassion satisfaction.

For this present study, 17 eligible nominees who filled out the Pro-QOL 5 obtained overall high sum scores ranging between 40 and 50. It is important to note that due to the small number of potential participants, these 17 sum scores are not normally distributed and have no statistic meanings to be converted to standardized t scores. In consultation with the researcher's adviser, a sum score above 42 was chosen to be the

cutoff point for determining the *high* level of compassion satisfaction.

Interview Protocol. Rather than forcing respondents to think inside the boxes formed by researchers, meaningful and insightful information is more likely to be found in respondents' own words through semi-structured interviews (Patton, 2002). Based on the review of existing literature, the primary researcher developed an initial semi-structural interview protocol. The purpose of the protocol was to encourage participants to reflect on and elaborate on professional experiences pertaining to their resilient characteristics or resilience development as a mental health professional. In consultation with the primary researcher's advisor and dissertation committees, the interview protocol was modified for the first time. Further, two pilot interviews also conducted by the primary researcher in order to refine the questionnaires as well as to gain the researcher interview experience (of note: the primary researcher has previously conducted research on resilience and self-care patterns of mental health counselors as well as has over 3000 hours of postmaster's professional interviewing experience). The first pilot participant was a self-identified white male, licensed professional counselor (LPC), with at least five years of clinical experiences in community clinics and university counseling settings. The second pilot interview was completed with a LP at a community clinic. This second interviewee was a self-identified white male with at least five years of clinical experiences in both community and university settings. Both pilot interviews were conducted as if a real interview and were audio-recorded. Also, a 15-20 minutes feedback time were built in after each pilot interview. Minor revisions were made based on feedback from the two pilot participants and in consultation with the researcher's advisor. These two pilot interviews were not part of data collections of this study.

The final interview protocol consists of 11 open-ended questions (see Appendix H). Interview questions 2, 3, 4, 6, 7, 9, and 11were intend to answer Research Question 1 (What are the characteristics of highly resilient therapists?). Interview question 1, 5, and 8 intend to search answers for Research Question 2 (Is there an innate or inner force that drives resilient therapists to grow through professional risks?). Interview question 10 was used to refine a better definition for "highly resilient therapists."

Procedure

Upon receiving research participants' agreement to take part in this study for a 60 minutes, in-person interview, the primary researcher began to contact them and schedule an in-depth interview. Prior to the interview, interview questions were emailed in advance in order to allow time for reflection and insight. The primary researcher's brief biography was included in the email because in qualitative research, researchers themselves are both the instrument for collecting and interpreting data at the same time (Patton, 2002). In each interview, the primary researcher also introduced himself and was open to participants' questions related to the primary researcher and this study.

During the summer 2014, the primary researcher conducted face-to-face interviews with the 10 participants using the semi-structured interview protocol. Each interview was audio-recorded. To ensure consistency and increase trustworthy, the primary researcher conducted all 10 interviews in person. In semi-structure interviews, interview questions were asked in the same order, which allows cross comparisons of participants' responses (Patton, 1990). Further, summary statements, follow-up questions or prompts for clarification and elaboration were asked when appropriate (Patton, 2002). Participants were encouraged to use their own words or phrases to describe

characteristics according to their answers in each question. Each interview was recorded by a digital recorder and transcribed verbatim. The primary researcher also made and then kept a field note right after each interview in order to record impression, interaction, and reflection of the interview. The average length of the interviews was 65 minutes. Participants expressed themselves at length. After all interviews were transcribed, each participant was offered a copy of the transcript of their interview for clarification and corrections.

Data Analysis

Given the small amount of existing literature examining resilient therapists, a qualitative approach of grounded theory (Strauss & Corbin, 1998) was used as the overall framework to guide the data analysis in the present study. Grounded theory provides an appropriate framework for a ground-level analysis because it "denotes a set of well-developed categories (e.g., themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework that explains some relevant social, psychological, educational, nursing, or other phenomenon" (Strauss & Corbin, 1998, p. 22). Data analysis was divided into three sections based on three research questions of the study. Namely, Coding Section I analyzed interview questions 2, 3, 4, 6, 7, 9, and 11 (characteristics); Coding Section II analyzed interview questions 1, 5, and 8 (force/energy); while Coding Section III synthesized feedback gathered from the interview question 10 (definition).

In the present study, the 10 interviews were transcribed and analyzed using Straus and Corbin's (1998) three-level data analysis: open, axial, and selective coding. Open coding is a process to identify and label the essence or meaning of the data. Through

open coding, concepts in the script will be extracted from raw data (words, phrases, or ideas) and emerge to higher-level concepts (themes/subcategories and categories) based on their properties and dimensions. Axial coding is a process of linking codes (concepts, themes, and categories) to each other. Through axial coding, degree of association and causal relations between codes will be examined. This process is similar to "putting together a series of inter-linking blocks to build a pyramid. The pyramid represents the entire structure, but blocks, and how they are arranged are the components that make it what it is" (Corbin & Straus, 2008, p. 199). Finally, through selective coding, a core category will be chosen and related systematically to other core categories. A main storyline that connects each component of the whole phenomena will be developed through the process of selective coding.

Validity

In this present study, this researcher's advisor served as an auditor to ensure the whole methodological process. Two peer reviewers were recruited to be part of the research team for data analysis. These two peer previewers were master's students in Marriage and Family Therapy (MFT) with strong interest in this study. Prior to data analysis, discussions pertaining to the research background, process of data analysis, qualitative methodology, principles and methods of ground theory, as well as published articles using ground theory as the main approach were provided by the primary researcher.

Several steps were taken to enhance the validity of this qualitative study:

1. Data Triangulation: In addition to a two-level, mixed-method selection of the research sample, data triangulation was employed with an intention to recruit participants

from diverse disciplines (e.g., counseling psychology, clinical psychology, social work, marriage and family counseling, etc), racial/ethnic backgrounds, and practice settings (e.g. university counseling centers, community clinics, private practice, etc.).

2. Reflexivity Technique: The research team engaged in self-examination prior to data analysis in order to identify investigator biases, expectations, or assumptions pertaining to resilient therapists. Researchers' biases and reactions to this research topic potentially influenced by individuals' demographic backgrounds were specifically examined and discussed before and throughout the data analysis process, and again in the closure team meeting. The research team meetings were formed in a mutual respectful and collaborative manner in order to create a cohesive environment within which each individual could openly share disagreements and reach consensus. Specifically, the primary researcher kept a memo of self-reflection (Corbin & Strauss, 2008) throughout the entire research process. Through the memo, he consciously reflected on thoughts, feelings, ideas, concerns, questions, problems, etc. The primary researcher's biases, expectations, and assumptions that could interfere with data collection and analysis were noted in order to maximize the validity of the study.

3. Member Checking: In order to increase trustworthiness, this study was designed to interview 10 therapists, rather than an N=1 study. Between winter 2014 and spring 2015, all participants received emails pertaining to (1) a written transcript for clarification and verification, and (2) initial results of the data analysis for additional thoughts and comments. Feedbacks from participants were incorporated into research results in order to increase the accuracy of the findings.

4. Peer Examination: The primary researcher and peer reviewers independently

reviewed and conducted coding on three random selected transcripts. Researchers examined transcripts line by line in order to identify and label words, phrases, sentences, quotations and ideas of each participant. The research team then met and discussed disagreements and discrepancies between coding results and perceived relationships between data, subcategories, and categories until a consensus was reached. After the initial list of coding was created, the auditor then verified transcripts and the initial list of coding and provided feedback in order to minimize researchers' biases or errors that might be brought to the study. Based on the refined list of coding, the research team then conducted the remaining coding through weekly meetings. New coding was added based on consensus after thoughtful discussion of disagreements and discrepancies. In the last stage of team meetings, the research team re-examined large amount of data and codes in order to identify a core category that might exist and systematically connect categories, subcategories and codes. Throughout the remaining coding process, the auditor constantly examined the results of coding in order to ensure the coding results fully explain the data. The final results of coding were also verified by the auditor. The data analysis process began in October 2014 and ended in January 2015. The research team met weekly during this time.

Chapter Four

Results

This study examines characteristics of highly resilient therapists (Research Question 1) and the force/energy that drives therapists to remain highly resilient over years of practice (Research Question 2). This study also intends to provide a definition of "highly resilient therapists" (Research Question 3). Using the qualitative research approach of grounded theory (Strauss & Corbin, 1998) as the overall framework, categories, subcategories (themes), and word/phrase characteristics were inductively extracted from participants' interview transcripts. In this chapter, examples of participants' responses will be presented in the form of illustrative quotations along with related categories, subcategories, and word/phrase characteristics. Minor editing has been done occasionally to the quotations to increase clarity.

Coding of this study was divided into Coding Section I (characteristics), Coding Section II (force/energy), and Coding III (definition), based on the three research questions. Answers to interview questions 2, 3, 4, 6, 7, 9, and 11 relate to Research Question 1 (characteristics); answers to interview questions 1, 5, and 8 relate to Research Question 2 (force/energy), and answers to interview question 10 relates to Research Question 3 (definition). Results of data analysis of Coding Section I (characteristic) and Coding Section II (force/energy) were eventually merged together during the data analysis process and yielded four categories (See Table 4.1): (A) Drawn to Strong Interpersonal Relationships; (B) Possess a Core Values and Beliefs Framework; (C) Actively Engaged with the Core Self; and (D) Desire to Learn and Grow. A central characteristic, *connectedness*, was also identified. In other words, responses in these four

categories reflect answers to both Research Question 1, "What are the characteristics of highly resilient therapists?" and Research Question 2, "Is there an innate or inner force that drives resilient therapists to grow through professional risks?" During the weekly meetings of the research team, an agreement on the convergence emerged.

As described in Chapter 3, there were three levels of the coding processes (Straus & Corbin, 1998) used by the research team, the open coding process, the axial coding process and the selective coding process. In the open coding process, concepts were grouped into broader subcategories based on similarity. In the axial coding process, in which the researchers intended to examine and confirm whether connections and relationships did actually exist between categories, subcategories and concepts, a pattern between Coding Section I and Coding Section II gradually became vivid to the researchers as we read one transcript after another—that is, categories and subcategories emerged from Coding Section I (characteristics) strongly connected with categories and subcategories emerged in Coding Section II (force/energy). This pattern was further confirmed in the selective coding process, in which the research team systematically re-examined transcripts, coding and memos in order to ensure an internal consistency among these categories.

The next two paragraphs give examples of how Coding Section I and Coding Section II merged. The connection between Coding Section I and Coding Section II was common in the transcriptions in that characteristics recognized by participants tend to center around the force/energy they identified. For example, see Figure 4.1, in Coding Section I (characteristics), one participant recognized "hopefulness" as an important characteristic that sustains her resiliency. In the open coding process, "hopefulness" and

its related concepts (e.g., positivity and optimism) were grouped into the subcategory of Have a Personal Values/Beliefs Base, and later emerged in the higher category of Possess a Core Values/Beliefs Framework. On the other hand, in Coding Section II (force/energy), this same participant identified that "Narrative practice and ideas," "faith," and "Christianity" served as her major force/energy. These concepts were grouped into the subcategory of Have Theories/Theoretical Approaches as a Roadmap and Have a Personal Values/Beliefs Base, and then emerged in the higher category of Possess a Core Values/Beliefs Framework, which is identical to the coding results of this participant's Coding Section I (characteristics). Consequently, emerged categories and subcategories of Coding Section I (characteristics) and Coding Section II (force/energy) became interlinked in the results.

The research team and auditor therefore agreed to merge the findings of Coding Section I and Coding Section II—that is, four categories, their associated subcategories and their related word/phrase characteristics presented in this study reflect both characteristics and the force/energy of highly resilient therapists. In fact, the interchange between characteristics and force/energy in this study was noticeable during the interviews. When asked about interview questions 1, 5, and 8, nine out of ten participants were able to identified forces and associate characteristics that sustain their resilience. One participant found it difficult to say whether there is a separate force/energy or if it is characteristics that serve as the force/energy for her.

Each of the other nine participants identified similar forces/energy and characteristics. For example, one participant identified "love of learning" as her force/energy and identified "support and connections from family and professional

community" as her characteristics. For another participant, "drawn to interpersonal connections" is a force to him yet "desire to learn" is one of his important characteristics. Therefore, characteristics and force/energy are exchangeable and interlinked according to participants' responses in this study.

Further, due to the complex responses of participants, for the most part, results of this study only include multiple coded data; that is, only data coded multiple times across different transcripts was included in the results. Moreover, the research team and auditor agreed to diminish overlap between subcategories/themes and word/phrase characteristics. Thus, despite a number of word/phrase characteristics that appear to be associated with more than one category, they were only grouped to the closest categories based on consensus between the research team and auditor. For example, although the characteristic of "humility" may associate with more than one subcategories, we chose to only categorize humility under the subcategory of Have Valuable Profession Relationships. We did this based on the idea that humility can be linked with willingness and openness to receive feedback. Therefore, only a succinct numbers of subcategories and word/phrase characteristics are presented in the results. With regard to the transcriptions and initial coding results that were sent to all participants for clarification and verification, one participant replied and provided feedback. This participant's feedback and comments were incorporated in the research results.

Figure 4.1 Visual Representation of Merged Coding Section I and II

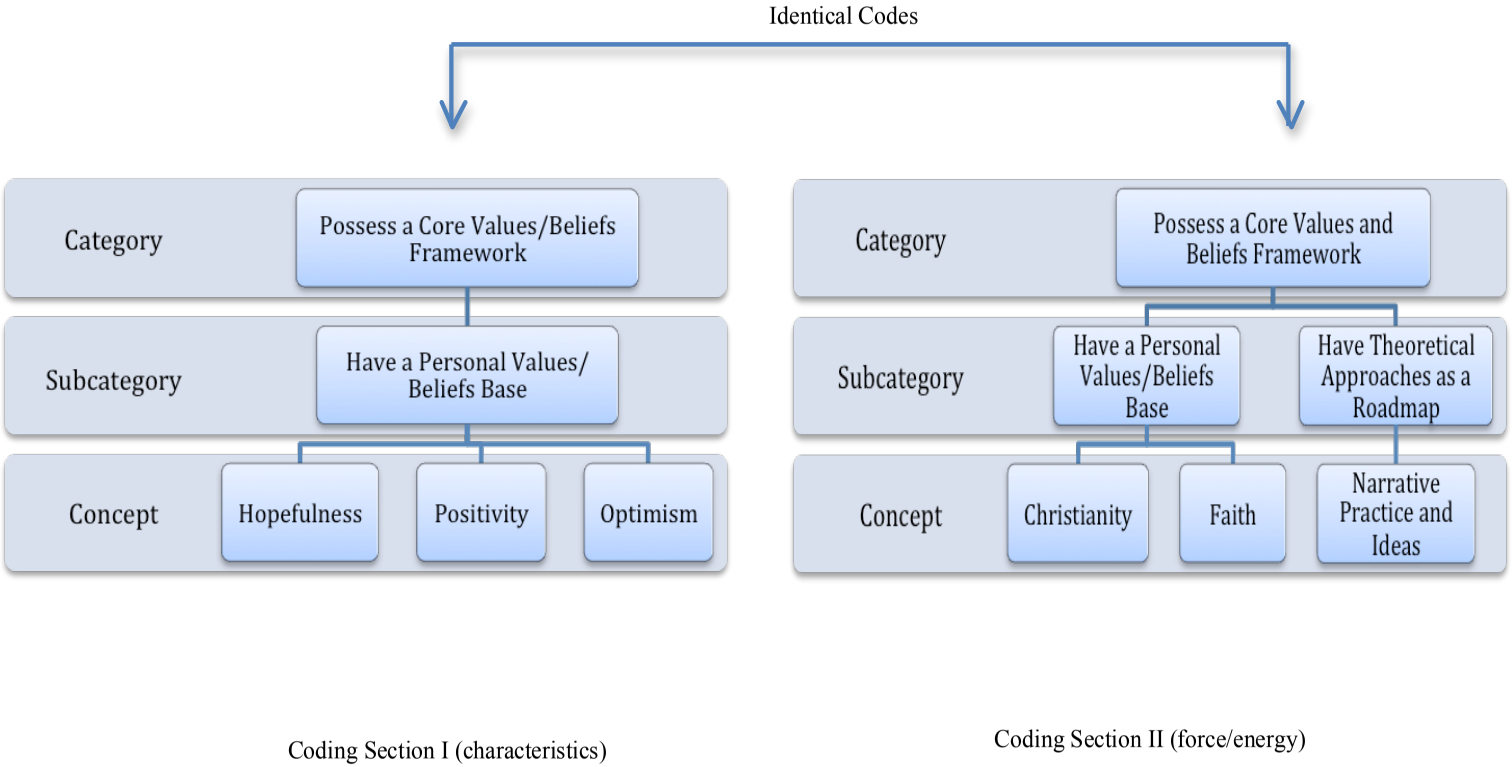


Table 4.1 *Characteristics of Highly Resilient Therapists*

Central Characteristic: Connectedness		
Category	Subcategory/Theme	Word/Phrase Characteristics
A. Drawn to Strong Interpersonal Relationships	A-1: Strongly Connected to Personal Relationships A-2: Stay Connected to Valuable Professional Relationships A-3: Have Compassion for Others	• Feel Loved and Supported • Humility/Openness/Vulnerability to Feedback • Love/Kindness/Compassion
B. Possess a Core Values and Beliefs Framework	B-1: Have Theories/Theoretical Approaches as a Roadmap B-2: Have a Personal Values/Beliefs Base	• Trust/Faith/Acceptance of Ambiguity/Patience • Hopefulness/Positivity/Optimism • Gratitude/Appreciation/Honor
C. Actively Engage with Core Self	C-1: Have Self-Knowledge C-2: Have Compassion for Self C-3: Have Vocational Conviction C-4: Fiercely Engage In Self-Conservation Mode	• Self-Acceptance/Contentment • Transparent With Clients • Authenticity/Equality Between People • Courage • Boundaried Generosity • Assertive in Creating a Balanced and Fulfilling Personal Life • Humor • Playfulness/Lightheartedness/Creativity

(continued)

Table 4.1 *Continued*

D. Desire to Learn and Grow	D-1: Desire to Ongoing Intellectual Development D-2: Committed to Ongoing Personal Growth	• Curiosity • Commitment/Persistence/Determination/ Dedication • Intentional Self-Reflection/Self-Awareness

Central Characteristic

"Connectedness" was consistently coded across the coding process and was richly connected to each category, subcategory and related word/phrase characteristics found in this study. To better reflect its relationships with each category, subcategory and word/phrase characteristic found in this study, a detail description of this central characteristic will be presented later.

Category A. Drawn to Strong Interpersonal Relationships

This category encompasses subcategories related to personal and professional connections. Participants generally identified strong interpersonal connections with family, friends, and colleagues in both their personal and professional lives.

(note: Minor editing has been done occasionally to the quotations to increase clarity.)

Subcategory A-1: Strongly Connected to Personal Relationships

Participants said that close interpersonal connections in their personal lives were essential for sustaining a fulfilling life. A participant stated:

> If I can't talk to people and be close to people, have friendships and close relationships with my family I suffer for that, if I can't do that, and if I do those things then I am well connected and my life is good…the things that I grab onto are my relationships with other people and that the web of connectedness that I feel with the people in my life, that's my family and my friends are the things that are the web that help me to maintain my life and make it agreeable.

Another participant expressed a similar statement:

> I live a [professional] life where I really leave that in large part at the door and come home and be a different person. I connect with my family and get a different thing through that connection.

Subcategory A-2: Stay Connected to Valuable Professional Relationships

For the participants, professional relationships in their work life with colleagues, consultant groups, or professional communities are as important as relationships in their personal lives. A participant described a significant long-term connection with an online consultation group. She said:

> I'm not in a vacuum. I think having a community like my friend now in Washington. I've never met her in person, but we're very good friends. We started in an on-line consultation group in 2010, and we've been chatting pretty much ever since.

Another participant shared her valuable connections with a consultation group. She said:

> I got connected with a consultation group of wonderful therapists. I really admire their work and them as people. We meet monthly. We email a lot…To staying oriented in this field, I guess it's not a good idea to be a lone wolf. It's a hard job and it's isolating enough as it is. It's important to stay connected. I noticed that was the key and I've never left that group.

Subcategory A-3: Have Compassion for Others

Participants value their relationships with clients and show compassions for them. With clients, participants bounce back from boredom, apathy or depletion and remain a caring heart over years of practice. They are able to be present with client after client. Here are two quotes:

> I think I am really touched and moved when people make progress, and usually I let that show. I think people know I care.

> The people that I see I believe they see me as being very caring and empathic.

Participants also show compassions for colleagues. They remain emotional available to colleagues at work and strive to provide a supportive working environment for all. Highly

resilient therapists appear to be important members of their professional communities. Here are two quotes:

> [I value]…being available, emotionally available to them [colleagues]…there's nobody that doesn't have hard stuff in their life. Struggles, personal struggles and their professional struggles, and then able to be honest and open, not with all colleagues but with close friends or colleagues.

> I think I work in a very positive environment with colleagues who are really supportive and feel very much like family... If I have been positive for them, or if I had to try to buoy them, then you naturally are doing that for yourself as well.

Related Word/Phrase Characteristics. The following word/phrase characteristics are strongly associated with Category A.

Feel Loved and Supported. Receiving and experiencing unconditional love and support from loved ones are important resources for nurturing resilience. One participant stated:

> There are some things that have changed over time and some things that haven't. So I would say that some of the external things that have not changed is having very supportive family, just that kind of unconditional…no matter what happens, I love you…that kind of support. And so, that has always been a resource.

Another participant shared how her spouse supported her career and professional development. She said:

> I think also having personal support. A husband who said when I had small children at home, "Go off. Go do that training. Get what you need to feel more anchored."

Participants also feel loved and supported by intentionally staying connected with professional colleagues who share similar passions, values, or viewpoints. Here are two quotes:

> I think I do surround myself with folks like myself...Who have a similar passion, and a similar drive.

> I have always been able to get along with whoever I work with [professional colleagues], but to feel so richly grounded in the same philosophies and ways that we work …Yeah we can challenge each other. We have some different ways going about things, but that's huge and more grounded in that value of not seeing people as problems or under a pathological lens.

Humility/Openness/Vulnerability to Feedback. Participants also share a commonality in their comfort with disclosing what they do not know in front of trustworthy colleagues. Participants humbly show their vulnerable sides and openly ask for feedback or constructive criticism. One participant said:

> The vulnerability is talking about things that you don't feel are going well in your client work. It means sometimes talking about how you feel about clients when that's not always rosy. I have some clients that I don't always enjoy. I can still feel committed to them, but talking about that and not being just completely and totally accepting all of my clients, that's vulnerable…What we share is that kind of commonality of this can be a hard thing in this work. If I'm not vulnerable in sharing those things [with professional colleagues], I wouldn't get to have that experience.

Another participant also mentioned characteristics of vulnerability, humility and openness in her professional community. She said:

> That unconditional acceptance of the community allows me to go in to consult and be vulnerable with those things. It also allows me to really hear the constructive criticism.

Love/Kindness/Compassion. The subcategory of Have Compassion for Others expresses that participants strive to be emotional available to clients and colleagues. Love, kindness and compassion are important characteristics in participants' everyday life interacting with others. Here are two quotes:

> In terms of the suffering of others, again, if we're living, there's pain and suffering, and I trust whatever has manifested for people. So, in the private practice realm or in psychotherapy, because I've experienced so much pain and suffering in my own personal life, I feel there's not much I'm afraid of. So, I can stay open and have compassion, love and kindness for whatever is being

presented to me.

> I'm just responding to you [clients] in a moment from who I am, and you are being you, and we are just together. I don't know can we call that love?... I will just do what needs to be done in order to maintain that connection in order to do whatever it feels like I need to do to support the therapy. I don't think twice about it even if it is probably more than I should be doing, and maybe I should think twice about it, but there is something about it almost not even having to think about it. It is almost just maybe it is like a parent. You just do what needs to be done for the child. You don't even think twice, and so maybe that makes it easier, or it's just part of what has to happen and so you do it.

Category B. Possess a Core Values and Beliefs Framework

Despite coming from a variety of cultural and spiritual backgrounds, participants all recognized the importance of having a worldview to understand themselves, clients and what happens in the world. Through the core values and beliefs framework, participants make sense of human suffering, confirm that their work has meaning and is helpful to others.

Subcategory B-1: Have Theories/Theoretical Approaches as a Roadmap

Theoretical models, approaches, or orientations provide a frame of reference in participants' clinical work. Theoretical approaches serve as roadmaps that help guide participants' work with clients. A participant shared how Narrative Therapy provides a useful lens for perceiving clients' problems:

> What has allowed me to stay fresh and resilient is that I very much resonate with narrative practices [Narrative Therapy] and ideas where folks are very separate from their problems…this is my lens that I wear when I am in the room with people and these narrative practices of separating people from their problems and seeing people as people and helping to strategize, and how they can stand up against problems and live more intentionally.

Another participant shared how his theoretical approach informs his clinical work. He said:

> Having a way to understand has been very helpful to me…that certainly has helped me to understand how I can help people through difficult times. It also helps me how I can help myself through difficult times…I utilize relational theory that's psychoanalytic but not in the old sense, it's more of developmental psychopathology and attachment theory. Those are the things that really inform a lot of the work that I do.

Subcategory B-2: Have a Personal Values/Beliefs Base

Personal values and a belief system provide a purpose for participants' work and their understanding of the meaning of human existence. Although participants identify with different spirituality or religion orientations, their worldviews play a significant role in sustaining their resiliency. In order to depict the consistent personal values/beliefs base between participants from different spiritual/religious backgrounds, quotes of participants from four different identified spiritual/religious backgrounds are included:

> I think I have a really core belief that every person has within themselves what they need to change and to get better... It is a Native American characteristic to be quite accepting of people, whatever is going on with them, to be accepting without judgment. That was something that I think I naturally had... We accept you as a person and we honor your ability to make decisions for yourself. (Identified with Native American Spirituality)

> Yeah, I think I have a very deep faith. It's not grounded in religion. It is grounded in what I have yet to name... It's a cellular level with the universe. I absolutely believe in something beyond what we see, identify, feel. I have no idea what it is or what I could describe it as right now. (Identified with no spiritual preference)

> I feel like I have the ability to see beyond suffering and see beauty in people and wholeness…there's a spiritual belief in me of the wholeness of a person that the suffering and all of that doesn't take away. It doesn't diminish them and who they are and so I'm always holding on to that. People come here feeling very broken… I'm trying to fan the flame of the good and potential… it keeps me very hopefully and grounded, because it's a connection with beauty, it's a connection with wholeness and it's spiritual. (Identified with Christianity)

> It's my own personal development with my own spiritual practice, Engaged Buddhism, which means it's in your life. Then directly transfers into my way of being with people and with people in my private practice…this is my belief, and it comes from Buddhism. If we can open to our own pain fully, our heart is open

> and we can connect very deeply with the pain and suffering in other people. (Identified with Buddhism)

Related Word/Phrase Characteristics. The following word/phrase characteristics are strongly associated with Category B.

Trust/Faith/Acceptance of Ambiguity/Patience: Core values and beliefs, either based on a theoretical approach or personal spiritual/religious values, seem to firmly ground participants. Then they are capable of fully trusting the therapy process and accepting clients as who they are. Rather than forcing a concrete solution on the unknown, participants are patient with ambiguity in the therapy process. Here are four quotes from different spirituality/religion identified participants:

> The creator already built something in people, so that people have within themselves something that they can cure themselves, that's what you [as a practitioner] really trust. (Identified with Native American Spirituality)

> If you're [as a practitioner] saying, "No, I'm willing to go [continue the therapy process] while not knowing what's going on here, and trust that it's going to come ... it will come out, we'll eventually figure it out, we'll figure it out together."... If you don't have the tolerance for it, either you're not going to do it [work the therapy process], and you're going to be very rigid with people, or you're going to manage it, white-knuckle it through there but it's going to come at a big cost. You're always going to feel as though there's something wrong with you [if you cannot let the confusion of the therapy process continue] because you don't know what's going on. (Identified with no spiritual preference)

> I think that faith can tie into that as well and faith that there is something greater than us, and that sometimes we need to just allow space for that, and to allow space to let things go and realize it's out of our hands, and that there's a greater power…that can allow a different kind of space for people sometimes, and a different level of hope. I can utilize prayer or meditation, that sort of thing…Patience would be a big one. You need to be really patient with people and hold that space, and let growth unfold in time. Maybe it comes back to patience, but the broad perspective is not getting really narrow and problem focused. Really holding this larger lens of what can be possible, it would come back to that hope…It would come back to what can be possible, and again just hanging in there with folks. (Identified with Christianity)

> Trust and faith in whatever is happening...I totally trust and believe in that when conditions are sufficient, things manifest. I trust that. And then try to stay open to what can I learn from that experience, and how will that then carry me into whatever develops next. So I totally trust and believe that there is learning that can come from those turning points or those difficulties, and I trust their presence…that conditions have come together to have this, be here right now, and so how can I most skillfully deal with this…it is patience, because people have their own timing and process, and we're not failures if they have a different timing than we have. (Identified with Buddhism)

Hopefulness/Positivity/Optimism: Even if clients bring into the therapy room various adversities in their lives, participants perceive adversities as an opportunity for transformation. Participants see gifts inside clients' difficulties, and they remain hopeful, positive, and optimistic. Here are four quotes:

> Things can get hard, but I'll be looking at the bright side or try to find the positives or the strengths in client situations. There are times where you get really beaten down or the client themselves is very beaten down, but I do remain hopeful or positive. (Identified with no spiritual preference)

> I'm willing to take on a case… that's hard, they doesn't seem very hopeful…I think I have a really core belief that every person has within themselves what they need to change and to get better…It is really more about facilitating what's in them. I think that has grounded me as a therapist over the years, that is really strong. (Identified with Native American Spirituality)

> I feel like I really am so connected with folks in the room, but certainly when there's days where you have heard one too many of these difficult stories of people's traumas and that can taunt and test the hopeful, the positive, the optimism…I feel like I can get taunted by that in moments and sometimes in days, and that's when I have to step back and remember that this is a process, and what can unfold in this process, and that along with the difficulties that happen in this world and injustice and unfairness, there is also these beautiful, positive, hopeful, wonderful things that come forward too. (Identified with Christianity)

> I stay pretty steadfast, which is again that faith and trust with what I believe and my understanding, that no matter how much suffering and pain, there is some setbacks or challenges. There are opportunities for growth and learning. So it's trust in that process also…Optimism, according to how he [Vaclav Havel] defines it, is that you believe in something even if everything that is coming your way is trying to destroy. Immediately there may be no change but you remain steadfast and work towards that. (Identified with Buddhism)

Gratitude/Appreciation/Honor: Participants identified these word characteristics along with hopefulness, positivity, and optimism. Participants feel honored to work with clients in many different ways. Through witnessing clients' resilience in facing various adversities, participants experience a sense of gratitude and appreciation. They perceive clients as a gift to them— that is, clients' help-seeking process is actually an opportunity for therapists to receive a gift. Below are four quotes:

> I am always amazed at...the resilience of the human spirit...I'm always really amazed at how people overcome things. (Identified with no spiritual preference)
>
> I feel just in awe and honored to be with people in the work that I do… I'm just in awe of the capacity of the human heart, and my belief in that. (Identified with Buddhism)
>
> I'm so honored and privileged to be a guide along side of you and to have taken an anthropological view… Here is what I've seen within that. There usually are things that come forward from difficulties that allow people to position themselves differently in life. The whole posttraumatic growth versus posttraumatic stress idea. I think when people have that space to heal and to feel cared for and to feel that compassion and to be guided through that, there can be healing. It's really a privileged space for me. (Identified with Christianity)
>
> I think it's kind of a spiritual belief that has grounded me... when people come to therapy it takes a lot to do that…when people come in it's an honor, so that has grounded me as well. (Identified with Native American Spirituality)

Category C. Actively Engage with the Core Self

Participants not only try to be emotionally available to clients and colleagues, they are also deeply self aware of and mindful about themselves. Moreover, moving beyond awareness of their own strengths and limitations, what they are good at, participants are action-oriented for what they need to preserve the core self. They proactively take actions to assert what's right for their core selves. One can best capture

this self-nurturing when saying they excel at all three parts of emotion, cognition and action in preserving the core self. This resilient therapists are emotionally self-aware, think rationally, and act decisively in preserving their core selves. Without a healthy core self, they would not be able to continue positively engagement work with client after client that is essential to the work of the therapist.

Subcategory C-1: Have Self-Knowledge

Participants are aware of personal strengths, expertise, limitations, and even shortcomings. They are true to self and others about who they are. After experiencing threating incidents such as professional complaints, participants became aware and learned to accept their shortcoming. After sharing a traumatic incident, this participant stated:

> [The client] is very threatening… I find that to be very hard. I think being aware of our limitations is not a shortcoming. My shortcoming is I'm threatened by those situations.

Another participant recognized that self-knowledge increases trust of sense of self and her professional expertise. She said:

> I do consultation with a training analyst, psychiatrist, once a month, and we talk a lot about where my expertise will be particularly helpful, or will other kinds of approaches be better suited. That gives me a sense of really being able to trust my own sense of self...it also says part of being transparent is being able to acknowledge your expertise and knowing your limitations.

Subcategory C-2: Have Compassion for Self

Participants are kind to themselves. They find it helpful not to take things personal or harshly judge, condemn and compare themselves with other therapists. Here are two quotes that depict the way participants are kind and compassionate with themselves:

> I think that I have worked personally on being more compassionate with myself, and I think that that has reaped a lot of good things in terms of ebb and flow, things go well and they don't go well... It's just being able to be solid even when it doesn't feel solid to just be flexible with okay.
>
> I think what I would say is that when I fall into the behavior or practice of comparing myself to other therapists, that can cause disruption for me, because I can start to judge myself on somebody else's criteria.

Subcategory C-3: Have Vocational Conviction

Participants are committed to be true to their vocational self. They constantly examine and re-orient their vocational self and pursue a congruence between vocational aptitude and work. Participants fearlessly seek a right fit with the workplace, client populations, and professional roles in work settings such as agencies where they serve. To manage motherhood without scarifying her career, this participant fearlessly stayed in tune with her vocational aptitude. She shared:

> I have an affinity…We talk about really knowing yourself, and using that knowledge to really be helpful to people...I was a mom, and building this practice. One of the ways that I managed everything was to put my focus more specifically on learning to become the best couples therapist that I could be. Not trying to do it all [being good in many roles] I think really helped. Engage, find something I felt both intrigued in and interested in.

To respect personal strengths and limitations, this next participant took a risk and changed her work environment years ago. She said:

> Maybe another characteristic is that the resilient therapist is not afraid to take the risk of finding the right fit in their environment or in the work that they do… If I'm working at systems that don't feel good to me, or if I'm working with people that don't feel good to me, and I'm not able to have some equanimity around that, I'm willing to move. I find the right fit in order to be able to do the work...to be able to respect your strengths and limitations.

Subcategory C-4: Fiercely Engage in Self-Conservation Mode

One participant specifically uses a strong word "fiercely" to describe her efforts to conserve energy for family life. Resonating with this participant, all other participants emphasized the importance of intentionally engaging in self-care in order to prevent their personal wells from running low. A participant shared her efforts in engaging in the conservation mode. She stated:

> I also can be kind of fiercely protective of myself for my family. I want to have enough energy for my family, so I'll tend to set lots of boundaries like I can't do that anymore. Like going into conservation mode and make very intentional decisions about how and where I put my energy and will do things that I know are going to create resources again.

Similarly, another participant always makes sure she has "a health dose" of self-care. She said:

> I think it's really important to give yourself breaks to take time away…whether it's at the end of every day that you get away and that you have different facets to your job. I think that's important. Whatever it is that sustains you, I feel like it's really important that you make sure you do a healthy dose of that.

Related Word/Phrase Characteristics. The following word/phrase characteristics are strongly associated with Category C.

Self-Acceptance/Contentment. Echoing characteristics of Trust/Faith/Acceptance of Ambiguity/Patience, with steadfast core values or beliefs, participants accept who they are and perceive themselves as human beings like anyone else. They accept the fact that they may not be a good fit or know that they have done all they can with some clients. Meanwhile, they have a sense of contentment and remain resilient. Here are two quotes:

> Accepting that I am a therapist who may not be the best therapist for some clients and that is okay…I think one of the keys for me of how I can be a resilient therapist is be okay with I'm probably not the best therapist for everybody. Just accepting that is really pretty freeing and put me at ease. I don't have to be the best therapist for absolutely everybody.

> You know you're not Jesus; so, you're not the last person who can help this person, and you're going to become ineffective at some point because of what's happening... I realized that there are situations that come up now that I will say, "I will know I'm not the best person to handle this."

Based on core values and beliefs, participants are also aware of their responsibility and limitations as a therapist. They do not play God or hero or are eager to solve all clients' problems. They do not take over clients' responsibilities or responsibilities beyond their limitation as a therapist or as a human. Here are two quotes:

> I don't think of myself as the all mighty, I'm not going to solve all of your problems. I'm here to facilitate your own ability to do that.

> I guess the word that I come up with is humble and not responsible for fixing my clients. Even though that's maybe what they want, or what other people maybe imagine they should be getting in coming to therapy. I feel very strongly that I am in a position to be one part of a healing journey, a healing practice, a therapeutic or treatment-focused experience for each individual client. I'm one part of that. I cannot be all of it…[I say to myself] stay on your yoga mat, it's a sense of contentment with who I am as opposed to worrying about who I think I should be or who I might feel I need to be at some point.

Transparent With Clients. Parallel with the characteristic of Self-Acceptance and Contentment, as soon as participants realize that their work won't be helpful for clients, they refuse to be drained or become apathetic. To maintain high resilience, participants are transparent enough and say no to clients. Here are two quotes:

> We [with clients] have to be working together towards similar goals. It had been eight months where we were out of sync. It was draining me. Sometimes I think you need to learn how to draw boundaries and be aware when the work is not helpful and to be able to name that.

> I think one of the most important, and sometimes challenging things is to learn who you can help, and who you really aren't helping…I can really be helpful when both people are ready to roll up their sleeves, or even look at, "Maybe I do have a part." But if one person [of a couple] is fixed in pointing the finger at the other, I can't be very helpful, and sometimes I do refer at that point, or be transparent and say, "I think I've gone as far as I can."

Authenticity/Equality Between People. With self-knowledge of personal strengths and limitations, participants feel confortable to show their authentic self. They feel comfortable not to know all the answer or have to be the expert. Working with clients, participants perceive selves as a human being who also has pain and suffering in their personal lives. One participant let her true self comes through her work with clients. She said:

> Showing up and being who you are. One of the nicest compliments folks that I have consulted with have told me is "You are your job, and it really comes through." As they have gone on to elaborate, they have talked about feeling genuinely cared about and honored…I think there can be so much hype in grad school around keeping professional distance that people are not authentic and feel like they have to be an expert, know the answers, be distant. Be yourself and don't act weird would be my advice.

Another participant perceives herself as a human being like any of her clients who have struggles. She stated:

> I think in some ways it's a commitment to being one of us, to letting go of the sense of power that can come… sometimes I think the most powerful thing that a therapist offers is a sense of just the connection of "I hear you, I'm witnessing you and your journey. I respect you. I've got my stuff. You've got your stuff."

Courage. Needless to say, courage is an essential word characteristic in this category as well as in the category of Have Core Beliefs and Values. It takes courage to acknowledge and accept one's own limitations; it takes courage to show authentic self; it takes courage to be transparent with clients, and it also takes courage to fiercely engage in self-conservation mold as well as to pursue a career that fits one's aptitude. It also takes courage to have steadfast faith in one's core beliefs or values and trust the

ambiguity. In addition to related quotes listed earlier, here are a few brief and powerful quotes:

> "Courage to seek the right work environment."
>
> "Courage to take the risk of finding the right fit in their environment."
>
> "Courage to trust the process."
> "I think courageous is one of the things that people would have said about me because I hear that a lot. And to me, it doesn't feel courageous. It really comes from that belief, but I'm sure that it does seem really courageous."

Boundaried Generosity. The term "boundaried generosity (p. 137)" was first used by Skovholt, Jennings and Mullenbach (2004, Chapter 7). Despite that participants are generously present to clients with love, kindness and compassion, they remain resilient by being comfortable with paradoxical dynamic with clients. They are engaged, compassionate, and care for clients; on the other hand, they also do not enmesh nor over-attached. They consciously engage and then separate from therapeutic relationships as they also nurture love, kindness and compassion selves. Here are two quotes:

> I know that there's something in me that is very drawn to paradoxes…A session can be energizing, not draining. That part feels really key to resilience to me...It's like you are engaged but you're not attached and you can separate.
>
> I think the work can be very beneficial and our relationship can be beneficial, but don't fool yourself into believing you're the one doing this for them. There's been other times where I feel like..."But I really have to get to work," and it seems like it never fails that anytime I compromise for myself or my family or something like that, I go to down to work and all my clients no show or something. It's like the universe teaching me. Just don't take yourself so seriously. They don't need you in the way that sometimes you can talk yourself into believing that they do.

Assertive in Creating a Balanced and Fulfilling Personal Life. Participants have a sense of balance between professional and personal lives. They stay resilient by

purposefully engaging in personal relationships and self-care activities outside of work. One participant shared the importance of having a meaningful personal life by doing concrete things. He said:

> One has to have a personal life that's meaningful, and you have things that if you do that are worthy. I do some things that are very concrete in my free time. I built this building. When I built it out, I built an addition on my home. I've done a lot but I do like regular music. One of the reasons I'm in this building is because it allows me to have a music studio. There's a benefit of it. Having those kinds of concrete things is really helpful because what we do here is not often concrete. We don't get to the end of the day and say, "I wrote this computer code. I constructed this building. I made this widget."

Another participant shared her ways of self-care through various activities such as solitary silence, receiving support from friends, and connecting to natural cycles of life. She said:

> I'll make sure that I'm practicing my yoga, or I do my meditation and really taking that quiet time that I actually need. I also get support from friends. It's about going into conservation mode…I garden. Reconnecting to the natural cycles of life is very helpful to me. You plant seeds and they grow. You weed. You don't really know what's going to happen. You can plant the seed. You don't know what's going to come up. You don't really have control over it. You just keep tending it and year after year after year something different happens and things grow and things die and things get crowded out. There's always something to learn about all aspects of life. I feel very comforted by the natural world.

Humor. Participants have a sense of humor. Although their jobs are to dive into the clients' ocean of intensive emotion, they feel okay to laugh at selves, laugh with people, and laugh at the funny side of life. Here are two quotations:

> I have a good sense of humor. There's lots of things they probably seen over the years that have happened that I can laugh about. I can see the funny side of life.

> One thing that I haven't mentioned so far that I think is extremely important that has developed over time with me both personally in my life, professionally, interpersonally, and definitely in meetings with people as a psychotherapist is having a sense of humor, and the true feeling and experience of joy no matter what is happening in life. No matter what is happening, there's also joy nearby in your life. Being able to laugh at oneself.

Playfulness/Lightheartedness/Creativity. Echoing many word/phrase characteristics mentioned earlier (e.g., humor, positivity, trust…etc.), participants are able to maintain a playful spirit. They are light-hearted and try not to take themselves too seriously. Moreover, they are creative. This participant mentioned these characteristics in her workplace with colleagues:

> I know people see the lighthearted, playful, humorous side. I would say we're very playful at my work. That's not just me. That's my colleagues as well. I'm usually the instigator. That's why I think that goes along with that positivity. I don't get stuck. I really try not to get stuck in negativity.

Not only with colleagues, another participant also laugh with clients. She tries to be playful and creative in her work with clients. She said:

> If I'm starting to feel stuck in this conversation, I find that to be incredibly helpful to keep me excited and vibrant in my work to have options and to use creativity…it would be talking about things like "Gosh, when you experience this problem do you get an image with that and when you get that image, is it in color or black and white? Is it in front of you? Is it behind you? Do you hear voices with it?" …All of a sudden, they are like, "Oh my gosh! Now that I'm doing that, I can laugh at this problem where before I was feeling traumatized. I didn't realize I could get so creative and playful in these ways of working with problems."

Category D. Desire to Learn and Grow

Love of learning is clearly an important characteristics (or force) identified by most participants. They also pointed out that engaging in personal growth is as important as professional growth. This subcategory resonates with the subcategory of Stay Connected to Valuable Professional Relationships and subcategories under the category of Possess a Core Values and Beliefs Framework, and the category of Actively Engage with the Core Self.

Subcategory D-1: Desire to Ongoing Intellectual Development

Participants have a thirst to learn. As a life-long learner, they never feel they know enough, always want to know more and do a better job. These following quotes portray this characteristic:

> I think that I have a tenacious desire to learn, and that is a core force for me to stay vibrant and connected, it's a feeling that is humbling because you can never know enough. You're never quite enough…The excitement of constantly having something to learn keeps me very engaged.

As a life-long learner, participants' continual growth is not limited to professional development. Participants have desire to learn in many different aspects. This next participant shared:

> I can go to the Apple Store, and learn some new things about my Mac. I'm excited. I think that keeps me wanting to get better, to learn, to find out what other people are doing, and how will that help me do a better job with my clients…Love of learning. Yeah, I think that's a family value, my dad was a chemist and he died last year, but up until his '90s he was still learning and interested, and I think it kept him vibrant and alive and I hope for the same.

Subcategory D-2: Committed to Ongoing Personal Growth

With respect to learning, participants not only refer to intellectual learning, they also perceive personal learning and self-development as a significant part of professional development. A participant mentioned her self-growth through understanding difficult times in her life and her awareness of possible countertransference in her work. She stated:

> …I think that because of some of the difficulties I've been through in my own life and really allowing myself to feel and work through this, it has allowed me to be better in the room with folks to have a better understanding, to have more patience, to have more compassion. I think it's incredibly important too that we do our own work…focus on your self-growth.

Another participant has committed for 20 years to continual self-growth through personal

therapy. She shared:

> That relationship is one where I feel very known and very understood...I think being able to have my time to do my own processing is a huge part of what grounds me. I think that the ongoing process of understanding and knowing, seeing, understanding yourself, your reactions to things, how you are changing over time, your own process of change and growth...that commitment, I feel really strongly that therapists would benefit from being in therapy to some degree. That's what I do.

Related Word/Phrase Characteristics. The following word/phrase characteristics are strongly associated with Category D.

Curiosity. Curiosity is clearly a significant characteristic identified by most participants. A few participants actually described curiosity as the force/energy that drives their high level of resilience. The follow two quotes depict how curiosity results in participants' continual growth and development.

> There's this curiosity. Like one thing always leads to the next interest, the next thing that I want to understand, the next thing I want to develop in my practice…That has been the case from the very beginning. I remembered in that presentation when he [speaker] was talking about scaffolding and that made such an impression on me because it felt very true. It's like, I need this piece, I need to understand this or I need to work with this and then I'll put energy into that and practice with that for a while. Then very naturally, the next part will come of whatever that is...There's some excitement. It feels endless. It feels like I could live 10 lives and never come to the end of what there is to learn.

For this participant, professional consultation is the place she finds support that feeds her great curiosity. She shared.

> What drives that willingness to be vulnerable is my real curiosity, like I really want to know what's going on here. Some of it is like I want to feel better but really underneath it I think "What's going on here?"

Commitment/Persistence/Determination/Dedication. A participant described her dedication to do the best job she could. She indicated that continual professional growth is essential for staying resilient. She said:

> I feel very dedicated to my work and what I provide to folks…I am trying to do the best job that I can with people. I guess it would speak to that. I guess it would speak to my own interest in creativity and professional growth.

This participant describes her commitment and persistence to "stretch" her knowledge database through continual education or professional consultation, which is actually a way of self-development at the same time. She said:

> What I've been saying is that I'm committed. I work really hard…I think people see that I'm stretching, and always looking for ways to be helpful…I was on a conference call with a colleague and we talked together about our cases, and about wrestling together with what does this really mean in terms of the model that we're using...I think I'm well known to be very persistent. Come back again, and again, and there are other words probably in that realm that would describe me. Stubborn sometimes. Committed. Don't give up easily.

Intentional Self-Reflection/Self-Awareness. Participants consciously and purposefully reflect, process, examine, and monitor themselves and their work in order to do better work. This participant stated:

> I think I'm determined and self-aware, I take action to get a problem solved. I do what needs to happen here? I need to connect with the group. I need to read more about that. I need to not think about that. I need to set up boundaries with this person, identify what it is and then I start going. I'm monitoring my engagement level all the time, and I want to stay connected.

Another participant reflected on her personal growth and transformation from a place of fear to a place of love. Combining with core beliefs, her constant personal reflections and self-awareness help cultivate on-going personal growth as well as client growth. She stated:

> Now having thoughts, words, actions in life and intentions that increasingly come from a place of love rather than a place of fear. I was so fear-based from all the abuse that I experienced growing up, that transformation is what people would have seen who possibly nominated me [as a resilient practitioner]. I am not coming from a place of fear, but a place of love. And that [Buddhism] teaching and belief in it and cultivating that in myself and helping to cultivate other people is what has sustained me and been the transformative part.

Central Characteristic: "Connectedness"

"Connectedness" (e.g., "Stay Connected"; "Connection") was consistently coded across the open and axil coding process. This coding richly connected to each category, subcategory and related word/phrase characteristics and seems to serve as a main storyline that connects each component of the entire data. Without any disagreement or discrepancy, the research team reached a consensus and choose "Connectedness" to be the central characteristic and served as the selective coding. This decision was also approved by the auditor. Using "Connectedness" as the central coding, the research team was able to systematically orient and refine categories as well as to validate relationships existing between data. Below are example quotes (some have already been used above under the Categories) that depict the rich connections and consistency between this central characteristic and major categories. For example, this following participant shared her efforts to connect with personal relationships and nature. She said:

> I disconnect from work and go connect. I just came back from ten days at my cabin, so that's a lovely thing to do for the summer. That's where I go to be when I connected with family and I connected with nature…There's this part about needing to stay and connect.

Another participant shared her connections with professional relationships and how that helps her stay connected in her profession. She said:

> I got connected with a consultation group of wonderful therapists. I really admire their work and them as people. We meet monthly. We email a lot…To staying oriented in this field, I guess it's not a good idea to be a lone wolf. It's a hard job, and it's isolating enough as it is. It's important to stay connected. I noticed that was key, and I've never left that group.

In addition to staying connected with colleagues, connecting with clients is also important. This participant stated:

> As I was reading through these questions after you sent them. I was realizing that

> I thrive on connection, whether it's the connection with my clients or whether it's the connection with my colleagues. It is the connection piece.

Here are two other quotes that describe how participants connect to clients at a human level:

> There is a lot of joy for me in meeting the diversity of having that connection over and over and over again with different people [clients] despite their pain and sometimes you have the deepest connection with somebody who has the most pain. I think it is the capacity to really be connecting at a very human level…be able to receive or contain the [clients'] pain.

Another participant stated:

> Sometimes I think the most powerful thing that a therapist offers is the connection of I hear you, I'm witnessing you and your journey, I respect you.

This participant described how her spirituality plays a role in her connection with people in general. She said:

> It [spirituality/religion] keeps me very hopefully and grounded because it's a connection with beauty, it's a connection with wholeness, and it's spiritual, I think, in nature.

Another participant described how her personal values help build a sense of connection to the universe. She stated:

> I have a very deep faith. It's not grounded in religion. It is grounded in what I have yet to name of kind of my connection to, I absolutely have a sense of a connection… I don't even want to say spiritual in some ways, it's a cellular level with the universe.

Another participant shared how her personal values help her connect to her inner self. She shared:

> It is just reconnecting to what's much bigger. It's what's much bigger than myself. I'm not religious, but I borrow from many traditions…gardening helps me see attachment or non-attachment. All of those dynamics. Whatever is going on in life comes up on your yoga mat. It's a way I can actually connect with myself in a renewing way…Reconnected to the nature cycle of life and that helps you to reconnect to yourself.

For this participant, she shared the importance of connecting her sensory ability to nature:

> …Also, just to connect with all of my sensory experience, like smelling this piece of burned wood brings me back to standing with my dad when I was a little girl."…I always loved those things, but I think I learned more to value.

Another participant pointed out that her "desire to learn" plays an important role for staying vibrant and connected in the profession. She said:

> I think that I have a tenacious desire to learn and that is a core force for me to stay vibrant and connected, it's a feeling that is humbling in so many ways because you can never know enough. You're never quite enough… The excitement of constantly having something to learn keeps me very engaged.

One participant's statement apparently touches across major categories and serves as a wonderful summary for the section of central characteristic:

> The things that are important to me are, first of all, my connections with other people, my relationships. My closest thing to a core belief is that human beings are designed to connect with other people. That's what we're born to do, and that things that disrupt that are problematic. As an organism if things are going well, we connect well with other people, we make use of those relationships effectively in order to do all the things we're talking about today, to get through life's difficulties… the things that I grab onto are my relationships with other people and that the web of connectedness that I feel with the people in my life, that's my family and my friends are the things that are the web that help me to maintain my life and make it agreeable, and of course over the years my personal understanding [has grown too]…Developmental psychopathology and attachment theory are the things that really inform a lot of the work that I do. They don't tell the whole story but they tell a lot of it, and those things inform me also what's important in my life, if I'm going to have those connections with people. If I can't talk to people and be close to people, have friendships and close relationships with my family I suffer for that. If I do those things then I am well connected and my life is good."

Definition of Highly Resilient Therapists

Answers to interview question 10 reflected participants' feedback regarding the definition of "highly resilient therapists." A tentative definition was provided in the interview. The tentative definition is based on a critical literature review, in consultation with this primary researcher's adviser, as well as derived from a number of sources (Rønnestad & Skovholt, 2013; Richardson et al., 1990; Skovholt, 2001, 2005, 2012).

Throughout the interview, 10 participants all resonate with the tentative definition, while nine of them also provided additional thoughts. Strong feedback was that one cannot stay highly resilient without a fulfilling personal life. With an integration of (1) the tentative definition, and (2) the major categories found in this study, the research team and auditor agreed and finalized the following Definition of Highly Resilient Therapists:

> The highly resilient therapist has a strong web of vibrant connectedness. While working as a therapist for many years, a highly resilient therapist is able to be fully present for client after client. A highly resilient therapist has core values/beliefs and desires to learn. The highly resilient therapist is able to continually engage with self, maintain interpersonal connections, and bounce back from both personal and professional challenges. Over time, the highly resilient therapist develops recurrent optimism, as well as experiences on-going growth and fulfillment in both personal and professional life.

Summary

Through the peer nomination process, a total of 201 therapists were nominated as highly resilient therapists. Twenty of them met the minimum of three nominations required for entering the second-level sample screening. Using two scales (CD-RISC and ProQOL 5), ten eligible participants who scored high on both scales were identified and agreed to participate in an in-person interview. Of the 10 participants, 9 were female and 1 was male; age ranged from 41 to 70 years old. Nine participants identified as white and 1 identified as Native American. Seven participants were doctoral-level licensed psychologists, 2 participants were master-level licensed marriage and family therapists, and 1 was a master-level licensed social worker. One practiced at a college counseling center, 5 were in private practice, 2 were in community clinics (outpatient/day treatment), and 1 practiced both in a community clinic (outpatient/day treatment) and a private practice. The interview focused on the following research questions:

1. What are the characteristics of highly resilient therapists?

2. Is there an innate or inner force that drives resilient therapists to grow through professional risks?

3. How can one more accurately define the term “Highly Resilient Therapist”?

Grounded theory (Strauss & Corbin, 1998) was used as the framework of the qualitative data analysis. Based on research questions, data analysis was divided into Coding Section I (Research Question 1), Coding Section II (Research Question 2), and Coding Section III (Research Question 3). During the data analysis process, Coding Section I (Research Question 1) and Coding Section II (Research Question 2) were eventually merged together. Analysis of the 10 transcribed interviews (652 minutes) yielded four categories, 11 subcategories, and related word/phrase characteristics. A central characteristic was also identified. In the next chapter, I will discuss the results. Implication and limitations of the results as well as recommendations for future studies will also be provided.

Chapter Five

Discussion

Purpose of the Present Study

In the field of counseling and psychology, research pertaining to effects of counseling work on therapists has prominently centered on therapist deficits and impairment. Although researchers have begun to look at effects of counseling work on therapists from the perspectives of positive human development and prevention in the past two decades, pathology is still the mainstream. Some existing research has attempted to explore protective factors, adaptive coping mechanisms, or self-care strategies of well-functioning therapists, but their main focus has centered on what therapists need to "do" or "how to react" rather than what therapists need to "have" or "nurture" in order to "be," "become" and maintain resilient. Thus, moving beyond identifying risk factors, stressors, self-care strategies, or coping responses among therapists who are doing well, this study explored the characteristics of identified highly resilient therapists. This study also sought to investigate whether there is a forces/energy that drives or motivates resilient therapist to grow through professional challenges and remain resilient over years of practice. Further, this study also attempted to offer a comprehensive definition of "highly resilient therapists." Three research questions asked in this qualitative study of highly resilient therapists are:

1. What are the characteristics of highly resilient therapists?
2. Is there an innate or inner force that drives resilient therapists to grow through professional risks?
3. How can one more accurately define the term "Highly Resilient Therapist"?

Ten highly resilient therapists were identified through two levels of sample screening: (1) the peer nomination procedure, and (2) two survey scales. In-person, semi-structured interviews were audiotaped and transcribed verbatim. Grounded theory (Strauss & Corbin, 1998) was served as the framework of the data analysis. Coding of the study was divided to three section based on three research questions. The results of Research Question 1 and Research Question 2 were eventually emerged. As a result, four categories, 11 subcategories, related word/phrase characteristics, and a central characteristic were identified. In the following sections, categories, subcategories and their related word/phrase characteristics will be discussed within the three research questions.

Key Findings: Research Question 1: "What are the characteristics of highly resilient therapists?"

Analysis of the data yielded four categories, 11 subcategories, related word/phrase characteristics, and a central characteristic. An overview was presented in Table 4.1.

Category A. Drawn to Strong Interpersonal Relationships

Highly resilient therapists have a strong desire to stay connected with others in both personal and professional relationships. Results reveal that highly resilient therapists are ***Strongly Connected to Personal Relationships*** **(Subcategory A-1)**. A web of connectedness with family and friends help participants maintain a happy, agreeable life. For example, for participants who are also parents, having a supportive partner who said, "Go off. Go do that training. Get what you need to feel more anchored," work/life balance becomes possible. As a result, participants *Feel Loved and Supported* (word/phrase characteristics). Moreover, highly resilient therapists also ***Stay Connected***

to Valuable Professional Relationships **(Subcategory A-2)**. Participants make sure that they are not living in a vacuum or become isolated from others. To stay away from being isolated, they make efforts to connect and consult with colleagues in the workplace, professional community, or in online consultation groups. Highly resilient therapists also *Feel Loved and Supported* in their professional relationships, which allow them to show *Humility, Openness, and Vulnerability to Feedback* (word/phrase characteristics). Receiving love and support from colleagues, participants feel comfortable to consult and show vulnerability when sharing things or work that is not going well. They feel comfortable to openly and humbly hear constructive criticism. In addition, highly resilient therapists ***Have Compassions for Others*** **(Subcategory A-3)**. Working with clients one after another for years, participants are able to be present and show genuine empathy to clients. With colleagues, participants not only receive support and love from them, they also actively help establish a loving and supportive work environment. They strive to be open and emotionally available for each other and make the work place like a family. For highly resilient therapists, *Love, Kindness, and Compassion* (word/phrase characteristics) are center element to their interpersonal relationships.

This category is similarly to Lidderdale's (2009) investigation of resilient lesbian psychologists. In her study, the value of relationships was an important inner source used by resilient lesbian psychologists. Likewise, this category also shares commonality with Harrison and Westwood's (2009) study investigating protective practices among therapists who majorly worked with traumatized clients. In their finding, personal and professional relationships offered an important protective practice in order to stay away from being isolated and restore balance. Harrison and Westwood (2009) also found that

exquisite empathy was a protective practice. They used the term exquisite empathy for therapists' "ability to establish a deep, intimate, therapeutic alliance based upon presence, heartfelt concern, and love" (p. 213). This resonates with the subcategory of Having Compassion for Others and word/phrase characteristics of Love, Kindness, and Compassion. This category also supports Skovholt's (2012) Essential Resilient Practitioner Tasks that stresses the importance of nurturing personal relationships as a way to counter one-way caring relationships and create supportive professional relationships at work.

This category is also consistent with two clusters (protective factors) found in Werner and her associates' (1982) longitudinal study. They identified that Temperamental Characteristics (i.e., caring person) and Supportive Adults (e.g., surrogate parents, grandparents and supportive coach) are important protective factors that enabled vulnerable children to cope with adversity across time and stay resilient. Similar to Werner and her associate's findings, strongly connected to personal and professional relationships, and feelings of loved and supported were also found to be significant characteristics that enable therapists to cope with challenges and remain resilient in the present study. In addition, from a risk-factor oriented view, Leiter and Harvie (1996) systematically reviewed published literature between 1985 and 1995 across a variety of mental health disciplines. They concluded that one of the most common personal and environmental risk factors that contribute to professional burnout was the lack of social support from personal and professional relationships. The category of Drawn to Strong Interpersonal Relationships found in the present study explains well why highly resilient therapists are able to resist burnout and stay resilient.

This category also supports findings in the three master therapists studies (as reported in Skovholt, Jennings & Mullenbach, 2004). In both studies of master therapists and highly resilient therapists, humility, openness to constructive feedback, and engaging others with compassion are critical characteristics. This category is also consistent with the risk and protective factors associated with wellness and professional resilience among expert mental health practitioners in Mullenbech and Skovholt's (2011) study. In their study, actively constructing the restorative personal relationship, creating positive professional relationships, and proactively promoting healthy work climate were important themes.

Category B. Possess a Core Values and Beliefs Framework

Highly resilient therapists possess a core values and beliefs framework. The core values and beliefs framework provide a worldview for their understanding of the complexity of human nature, the joy, pain, and suffering as well as making meaning of their work and life. ***Having Theories or Theoretical Approaches as a Roadmap*** **(Subcategory B-1**), participants, therefore, have a useful lens to perceive and conceptualize clients' problems and difficulties. The roadmap not only informs participants' clinical work, it also provides a lens for understanding themselves through personal difficult times. Further, to understand the complexity of human suffering beyond the scope of clinical work, highly resilient therapists also ***Have a Personal Values/Beliefs Base*** **(Subcategory B-2**) aside from a theoretical roadmap for the clinical work. A Personal Values and Beliefs Base offers participants a more profound perspective in understand human suffering and injustice. Through a core values/beliefs base grounded in their family upbringing, personal experiences, spirituality, or religious

faith, participants are able to deeply connect with clients and understand pain and suffering in different worldviews. Therefore, highly resilient therapists have characteristics of *Trust, Faith, Acceptance of Ambiguity, and Patience* (word/phrase characteristic). With a core values and beliefs framework, participants accept clients as who they are in a respectful and nonjudgmental manner. When the therapeutic process becomes ambiguous, within their core values and beliefs framework, participants have faith and patience. They are able to trust the process. Participants trust that the unknown will unfold in time. Participants also have characteristics of *Hopefulness, Positivity and Optimism* (word/characteristics). When encountering clients who may be traumatized and hopeless because of injustice and unfairness in the world, participants remain hopeful, positive, and optimistic. With a core values/beliefs base, participants have hope and faith about the future. They trust that pain and suffering are a part of the process. Participants believe that there will be opportunity for growth, learning, and transformation that come forward. As a result, highly resilient therapists grow a sense of *Gratitude, Appreciation, and Honor* (word/characteristics) when walking with clients through their journey of transformation. They recognize and are in awe of the resilience of the human spirit among clients. Participants develop a sense of gratitude, appreciation, and honor in witnessing clients posttraumatic growth. Highly resilient therapists view that clients' help-seeking process as actually a gift-giving process to therapists.

In Harrison and Westwood's (2009) study of protective practice that prevented counselors from vicarious traumatization, findings suggested the importance of embracing the complexity of human conditions, having active and optimistic faith, trust and belief, engaging in self-care and finding purposes and meaning in clinical work.

Harrison and Westwood's findings share much with this category. This category also resonates with the Essential Resilient Practitioner Tasks (Skovholt, 2012) with respect to "relish the joy and meaning of the work as a positive energy source (p. 121)," "develop sustaining measures of success and satisfaction (p. 128)," and "connect with your own spirituality (p. 132)." Findings from this category are also consistent with Collins' (2007) work that stressed "hope" and "optimism" (p. 263) as significant personal characteristics of social workers so that they can sustain positivity in clinical work. Similarly, in Werner's (1992) classic longitudinal resiliency study, "hope" (p. 265) was identified as a central component for identified at-risk and vulnerable children for beating the odds and manifesting high levels of adaption and functioning. In fact, one important cluster (protective factors) Werner and her associates (1982) identified was Skills and Values, which referred to skills, values and spiritual faith that vulnerable children obtained in reaction to challenging situations and remain resilient. In the present study, counseling theories and skills as well as personal values, spirituality, or religion found were identified as essential characteristics that help therapists bounce back from challenges and develop recurrent optimism. Consistently, Masten, Best, and Garmezy (1990) indicated that "a growing appreciation of a latent construct that can be termed adaptability (p. 426)" is a significant functioning element associated with the nature and content of resilience. *Gratitude, Appreciation and Honor,* the word/phrase characteristics found in this category echoed well with Masten, Best, and Garmezy's (1990) views of resilience. Furthermore, this category seems to echo the "resilient reintegration" stage of The Resiliency Model (Richardson et al., 1990), in which individuals were able to gain insight of adversities and then restore, grow, and acquire qualities of resilience. Thus,

Category B, its related subcategories and word/phrase characteristics share much with Richardson's understandings of resilience qualities.

Category C. Actively Engage with the Core Self

Highly resilient therapists deeply and actively engage with their core selves. Participants engaged in ongoing understanding of selves in order to ***Have Self-Knowledge*** **(Subcategory C-1).** Participants continually acknowledge their strengths and expertise in order to advance their clinical work. They are also humbly open to learn and accept their limitations and also shortcomings. With evolving self-knowledge, highly resilient therapists ***Have Compassion for Self*** **(Subcategory C-2)** because they understand and accept personal limitations and shortcomings. When their work with clients does not go well, participants try not to take things personal. They do not harshly judge and condemn themselves or compare themselves to others. Participants are kind to themselves. Further, highly resilient therapists ***Have Vocational Conviction*** **(Subcategory C-3).** Participants not only have understandings of personal strengths and limitations, they are in tune with vocational affinities. Participants constantly exam and re-orient their vocational self. Thus, participants fearlessly and actively search for congruence between personal aptitude, expertise, workplace, client populations, and professional roles. Moreover, highly resilient therapists proactively balance their life and ***Fiercely Engage in Self-Conservation Mode*** **(Subcategory C-4).** Participants have compassion for self in their personal life. Through actively examination and management of their personal energy level, boundary settings, and engagement of self-care/nurturing activities, participants fiercely protect and conserve the core self.

Through highly engaging with the core self, highly resilient therapists grow a sense of *Self-Acceptance and Contentment* (word/phrase characteristics). Highly resilient therapists accept their true selves. They not only acknowledge personal strengths and expertise, but also accept personal limitations and shortcomings. Participants accept and are content with the fact that they may not be a good fit for every client. With a sense of self-acceptance and contentment, highly resilient therapists take action. As soon as participants realize that their work will not be helpful for clients or they might not be the best fit for certain clients, participants are not afraid of being *Transparent with Clients* (word/phrase characteristics). They feel comfortable to say to clients, "I think I've gone as far as I can," or "I'm not the best person to handle this." Fully accepting and respecting their true selves, highly resilient therapists genuinely show *Authenticity and Equality Between People* (word/phrase characteristics.) Participants are neither afraid of not knowing all the answers nor worrying about not being an expert. When engaging with clients, participants let their true selves come through and let people know that they are also human beings who equally have pain and sufferings in personal lives.

There is no doubt that highly resilient therapists have to be *Courageous* (word/phrase characteristic). Courage is a characteristic in this category and in Category B, Possess a Core Beliefs and Values Framework. To remain resilient, participants need to be courageous enough to acknowledge and accept their own limitations, to show authentic self, to be transparent with clients, to fiercely engage in self-conservation mold, and to be courageous enough to pursue a career and working environment that fits their aptitude. It also takes courage to have faith in one's core values and beliefs framework and trust the ambiguity of therapeutic process. Furthermore, although highly resilient

therapists are generous, they also have *Boundaried Generosity* (word/phrase characteristic). Participants are consciously engaged and compassionate in therapeutic relationships. Paradoxically, participants are cautious about over attachment. So, participants are conscious about when to separate from therapeutic relationships and when to nurture love, kindness, and compassion for themselves. To practice Boundaried Generosity, highly resilient therapists are *Assertive in Creating a Balanced and Fulfilling Personal Life* (word/phrase characteristics). Participants actively engage in personal relationships and purposefully engaged in self-care activities outside of work. They make effort to balance a personal life aside from professional life as well as to create a meaningful and fulfilling personal life. Highly resilient therapists also have a sense of *Humor* (word/phrase characteristic). Although participants' jobs are to dive into the clients' ocean of intensive emotion, they allow themselves to laugh at themselves, laugh with people, and laugh at the funny side of life. Highly resilient therapists are also *Playful, Lighthearted and Creative* (word/phrase characteristics) in their work either with clients or with colleagues. Participants never take themselves over seriously.

This category is relevant to several previous studies. In Mullenbach and Skovholt's (2011) study of peer-nominated mental health practitioners, results emerged of a category that consists of four themes associated with self-nurture behaviors that was similar to this category. Likewise, in Harrison and Westwood's (2009) study investigating mental health therapists who were doing well after years of working with traumatized clients, practicing mindfulness, engaging in self-care activities, setting boundaries, and recognizing limits were also found to be important protective practice. In addition, in Skovholt's (2012) Essential Resilient Practitioner Tasks, assertiveness in self-

care, create profound sources of uplifting vitality, balancing one-way caring of empathy, "have fun and be playful" (p. 139) are also identified as essential resilient tasks for developing resilience.

This category and subcategories, Have Vocational Conviction in particular, also support Maslach's burnout research. For instance, Maslach summarized years of her work (e.g., Schaufeli & Enzmann, 1998; Maslach & Leiter, 2005; Maslach, Schaufeli & Leiter, 2001; Maslach et al., 2001) from the perspective of the social and organizational environment. They concluded seven major organizational risk factors that contribute to professional burnout. These risk factors included: excessive workload, little role control, insufficient reward, little sense of community, lack of fairness, conflicts between individual and organizational values, and incongruity between personality types and work environment (Maslach & Leiter, 2008). These organizational risk factors are closely relevant to the subcategory of Have Vocational Conviction in the present study. Highly resilient therapists in the present study were found to have self-knowledge and self-compassion, and courageously carry vocational convictions in pursuing a work environment that is congruent with the personal aptitude, expertise, and professional role.

It is important to note that this category of Actively Engaged with the Core Self has crucial components of "self" and "action taking," that seems to resonate with the "self-righting mechanism" (p. 202) proposed by Werner and Smith (1992). After years of longitudinal studies tracing children at risk to their adulthood, Werner and Smith concluded that resilience is an innate self-righting mechanism within every individual. Similarly, Richardson (2002) also proposed that resilience is a source that drives individuals to "seek self-actualization, altruism, wisdom and harmony with a spiritual

source of strength (p. 313).” Werner and Smith’s concept of “self-righting mechanism” and Richardson’s concept of “resilience as an inner source and drive” closely related to this category that focuses on “self” and “action taking.” Coincidentally, in Lidderdale’s (2009) investigation of resilient lesbian psychologists, internal resources were found to be used in the resilience process. These internal resources related to this category of this current study include “an inner sense,” “values of an inner life as important,” “action-oriented,” and “determination (p. 182).” In fact, the category of Actively Engaged with the Core Self also seems to associate with self-nurture behaviors found in Mullenbach and Skovholt’s (2011) study. One theme, “participant value an internal focus” (p. 221), strongly related to the self-righting, action-oriented emphasis of this category.

Category D. Desire to Learn and Grow

Highly resilient therapists have tremendous love of learning. They desire to learn for both intellectual growth and personal growth. Consistent with connecting to professional consultation and humbly seeking for feedback in Subcategory A-2, Stay Connected to Valuable Professional Relationships, participants engage in learning in various ways. Continual growth in theoretical approach or spiritual/religious faith as mentioned in Category B, Possess a Core Values and Beliefs Framework, are also related to this category. Highly resilient therapists ***Desire to Ongoing Intellectual Development*** (**Subcategory D-1).** Participants feel that they can never know enough and are excited about engaging in constant learning. Through ongoing learning, they feel vibrant and alive. Further, echoing Category C, Actively Engage with the Core Self, highly resilient therapists are highly ***Committed to Ongoing Personal Growth*** **(Subcategory D-2).** Participants are determined and dedicated to gaining on-going self-knowledge, engaging

in self-awareness, examining themselves for possible countertransference. Participants connect closely with their inner self and are action-oriented for ongoing personal growth.

Highly resilient therapists are driven by endless *Curiosity* (word/phrase characteristic). Curiosity leads participants from one interest to another, and there is the endless excitement as they continue to understand and develop professionally and personally. The characteristic of curiosity is parallel with *Commitment/Persistence/ Determination/Dedication* (word/phrase characteristic). Highly resilient therapists are committed, persistent, determinant, and dedicated to their profession. They constantly "stretch" themselves and engage in continual professional and personal growth. Furthermore, highly resilient therapists engage in *Intentional Self-Reflection and Self-Awareness* (word/phrase characteristics). These two characteristics are also relevant to Category C, Actively Engage with the Core Self, in that all subcategories in Category C also require self-reflection and self-awareness before taking an action plan. In this category, participants purposefully engage in self-reflection and self-awareness in order to facilitate ongoing intellectual development and personal growth. Highly resilient therapists also engage in personal and professional growth through working with clients.

Category D is consistent with findings of Harrison and Westwood's (2009) study about therapists' protective practices. In their study, mindfulness, curiosity, and holistic awareness were found to be important practice for enhancing multiple perspectives. As noted in Lidderdale's (2009) study, determination and curiosity are also recognized as important inner resources for resilient lesbian psychologists. This category also shares much with studies of counselor development and master therapists. In a master therapist study (Skovholt, Jennings, & Mullenbach, 2004), master therapists were found to be

strongly longing for growth. Master therapists were "voracious learners (p. 136)", "committed, determined, reflective, self-aware (p. 133)" and "insatiably curious (p. 134)." Similarly, several themes concluded by Ronnestad and Skovholt (2013) are also consistent with Category D. For example, for optimal learning and professional development, they found that continual reflection and awareness are essential. To drive the developmental process, they concluded that an intense commitment to learning is prerequisite. Also, for master therapists, it is a lifelong process for professional development according to Ronnestad and Skovholt. These findings are consistent with this category.

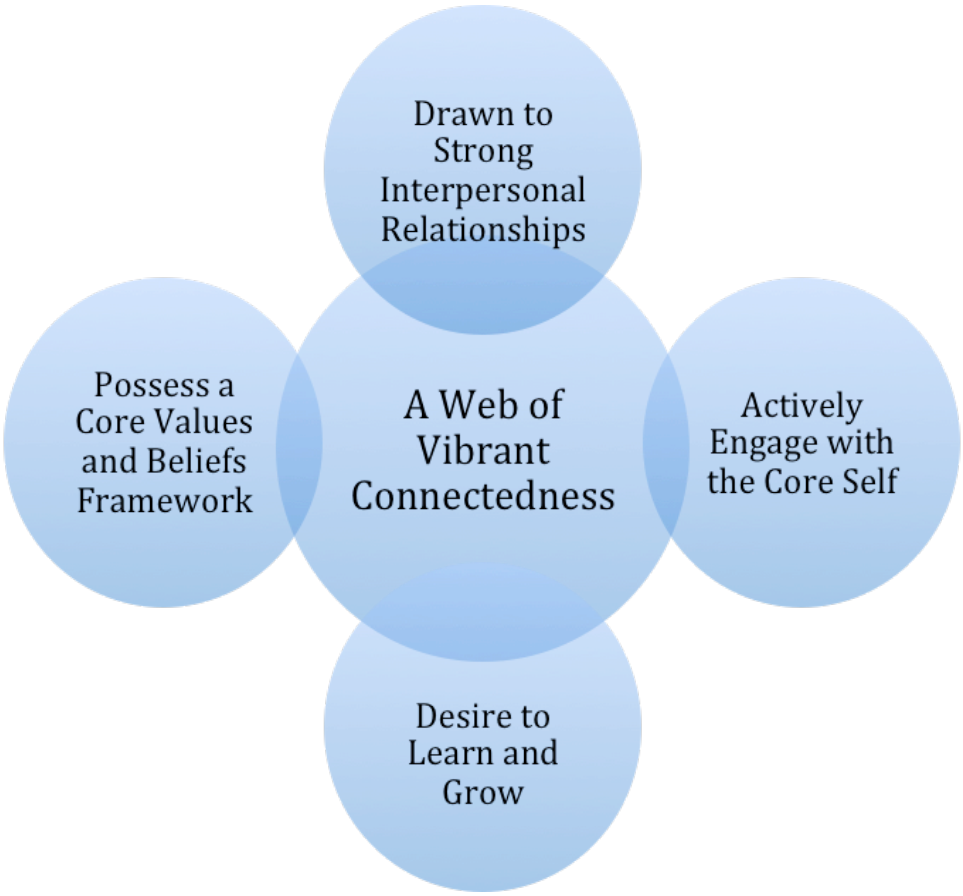
Central Characteristic: Connectedness

In conclusion, *connectedness* is the central characteristic of highly resilient therapists. Namely, highly resilient therapists have a web of vibrant connectedness. *Connectedness* was selected as the core characteristic because it existed across almost all categories, subcategories, and word/phrase characteristics. In the entire data, *connectedness* appeared to be the main story line that links each component of the results, and it helped "put together a series of inter-lining blocks to build a pyramid" (Corbin & Strauss, 2008, p. 199). In Category A, Drawn to Strong Interpersonal Relationships, participants manifested their longing for a sense of *connectedness* in personal relationships with family and friends. Participants also manifested their desire to get *connected* to professional colleagues, community, and consultation groups. In their clinical work, participants also manifested their passion in forming in-depth of *connections* with clients. In Category B, Possess a Core Values and Beliefs Framework, participants manifested their eagerness to stay *connected* to theories or theoretical

approaches that they resonate with so that they have a roadmap for clinical or personal work. Participants also manifested a strong sense of *connection* with personal values, spirituality, or religion so that they felt grounded in understanding and making meaning of the profound complexity of the human condition. In Category C, Actively Engage with the Core Self, participant expressed their desire to proactively *stay connected* with their core selves. They *connected* to the core self through gaining self-knowledge, being kind and compassion for self, carrying convictions of vocational aptitude and finding congruence between self and work settings, and fiercely protecting, preserving and nurturing personal need. Also in Category D, Desire to Learn and Grow, participants manifested their voracious desire for ongoing intellectual development and personal growth through constantly *connecting* to opportunities for continual education and intentional self-reflection and self-awareness.

It is noteworthy that that the central characteristic, *connectedness*, found in this present study plays a less central role in previous studies on therapist resilience, risk-factors, and protective-factors studies, and other related studies focusing on therapists' competence, proficiency, development and depletion. Thus, the central characteristic, *connectedness* found in the present study deserves more attentions in future resilient therapist studies.

Figure 5.1. Proposed Model of Characteristics of Highly Resilient Therapists



Key Findings: Research Question 2: "Is there an innate or inner force that drives resilient therapists to grow through professional risks?"

Results of data analysis of interview questions related to Research Question 2 eventually merged together with results of data analysis of Research Question 1 regarding characteristics of highly resilient therapists (See Figure 4.1). Namely, four categories, their associated subcategories and related word/phrase characteristics presented in this study reflect both characteristics and the force/energy of highly resilient therapists. This outcome is noticeable during the interview and data analysis process in that characteristics recognized by participants tend to center around the force/energy they identified. Also, characteristics identified by some participants were force/energy recognized by other participants. Therefore, characteristics and force/energy are exchangeable and interlinked in this study. In fact, when asked about interview questions related to Research Question 2, nine out of ten participants were able to identified forces and associate characteristics that sustain their resilience while one participant found it difficult to distinguish between whether there is a separate force/energy or if it is characteristics that serve as the force/energy for her.

As a result, to truly reflect the data, for Research Question 2, the research team concluded that characteristics and force/energy of highly resilient therapists are exchangeable and interlinked in this study. Even though nine out of 10 participants were able to identify forces/energy that drive them to grow through professional risks, one participant was not certain about whether there is a force or energy that drive her high resilience. Thus, as with any qualitative study, it is inappropriate for this present study to claim that there is a 90% possibility that there is a force/energy inside every therapist that

drives or sustains their high resilience. In other words, these nine participants' experiences of force/energy that drives their resilience may not be generalizable to other therapists."

In responding to the inner "self-righting mechanism" (p. 202) mentioned by Werner and Smith (1992), the findings of Category C, Actively Engage with the Core Self, seems to support this concept. However, it is inappropriate to conclude the search of forces/energy based on the congruence between "self-righting mechanism" and "Actively Engaged with the Core Self." Furthermore, Richardson (2002) stated, "there is a force within everyone that drives them to seek self-actualization, altruism, wisdom, and harmony with a spiritual source of strength. The Source is resilience" (p. 313). Even thought all participants identified with *Having a Personal Values/Beliefs Base* (Subcategory B-2), and some participants associated with spirituality/religion would agree with Richardson's statement, this may not be a case for participants identified with no spirituality/religion. For participants with no religion identification, their personal values may not necessary be based on spiritual or religious sources. Also, because no participants used the term "resilience" to describe their identified forces/energy, the results of this study were not able to provide support to Richardson's statement.

Key Findings: Research Question 3: "**How can one more accurately define the term Highly Resilient Therapist?"**

Derived from a number of previous studies (Rønnestad & Skovholt, 2013; Richardson et al., 1990; Skovholt, 2001, 2005, 2012) a tentative definition of highly resilient therapists was presented to participants during the interview. Based on the tentative definition, all participants shared their agreement on this tentative definition.

Nine of them provided additional thoughts. The major feedback topic was that a person cannot stay highly resilient without having a fulfilling personal life. In other words, when talking about therapists' resilience, personal and professional resilience go hand in hand. So, how do we more accurately define the term Resilient Therapist? Mirroring (1) the tentative definition, and (2) the major findings of the current study, the researcher team humbly offers the following definition of Highly Resilient Therapists:

> The highly resilient therapist has a strong web of vibrant connectedness. While working as a therapist for many years, a highly resilient therapist is able to be fully present to client after client. A highly resilient therapist has core values/beliefs and desires to learn. The highly resilient therapist is able to continually engage with self, maintain interpersonal connections, and bounce back from challenges in both personal and professional aspects. Over time, the highly resilient therapist develops recurrent optimism, as well as experiences on-going growth and fulfillment in both personal and professional lives.

This definition is rooted in the tentative definition that originally derived from Rønnestad and Skovholt's (2013) Phases of Therapist/Counselor Development, Skovholt's (2012) Eleven Essential Resilient Practitioner Tasks, Skovholt's (2001, 2005) The Cycle of Caring, and Richardson et al.'s (1990) The Resiliency Model, and later was integrated with major findings of the present study. Since these literature and findings of the present study were discussed in this and previous chapters, no further discussion will be provided here.

Study Strengths and Limitations

Study Strengths. A significant strength of this current study is the two-level, mixed method sample screening—the peer nomination procedure and two survey scales. With the first-level sample screening, information-rich cases were more likely to be selected to exemplify highly resilient therapists (Patton, 2002). With the second-level

sample screening, validity of this study was increased in that it ensured the information-rich exemplars, perceived as highly resilient therapists by others, also self-perceived themselves as highly resilient by scoring high on two resilience-oriented instruments. Additionally, although the sample was primary Caucasian with a majority of females, it did include some diversity in terms of discipline, practice settings, religions and culture. The sample was also a significant strength of this present study. First, in previous resilient-oriented studies, therapists who are considered at risk (e.g., David, 2012; Harrison and Westwood, 2009) are often those who worked with severe abuse or trauma-related clients. Ten participants in this present study work in general mental health settings (e.g., community clinics, college counseling centers, and private practice), which reflect the majority of mental health providers in the counseling professions. Further, in the present study, 201 therapists were nominated. The ten selected participants have between three and six nominations as well as scored high on both scales. The participants expressed strong motivation in participating in this study and openly shared their personal stories, deep struggles, vulnerability, and resilience experiences. Additionally, the interview protocol of this current study was based on the critical review of existing literature and consultation with the primary researcher's advisor who has extensive research experiences in counselor and therapist development, resilience and burnout prevention. Also, the ten in-person interviews were all conducted by the primary researcher who has extensive interviewing experiences in gathering data as a counselor and researcher. This primary researcher also participated in the entire data analysis to ensure validity and consistency between data collection and analysis. More importantly, rather than perceiving from a pathological-oriented lens, this current study has a resilient-

oriented focus of the invulnerable side of therapists. Also, moving beyond identifying risk factors, stressors, and coping strategies among therapists, this study used qualitative research method to gather in-depth information of characteristics from information-rich participants. A significant strength of this study is its contribution to a small body of research on resilient therapists and its attempt at offering a definition of "highly resilient therapists."

Study Limitations. As with any qualitative study, the results of this present study may not be generalizable beyond the context of the present group. In particular, for the peer nomination procedure of this current study, in order to increase the likelihood of multiple nominations, the geographic location of nominees was limited to the academic home of the primary researcher—Minnesota. The demographics of the population base of therapists in the state of Minnesota made it difficult to acquire a more diverse sample. Thus, the sample in this study may not be relevant in other geographic locations of the United States or in other countries.

Although the peer nomination procedure is a strength of this study as it helped recruit the information-rich sample, the chain that connects recommended key informants and nominees in the peer nomination process might be a potential attribution of the finding of the central characteristic, *connectedness*. Also, some well-regard highly resilient therapists might not be included in the nomination process due to different social or professional networks. Further, although this research made extra efforts to include participants from diverse backgrounds, the lack of gender and racial/ethnic diversity were another limitation of this study. Participants of this study were primary identified as females and Caucasians. Among the ten participants, only one participant is male, and

only one participant identified as a member of a racial minority. Therefore, it is possible that a male practitioner from a non-European racial/ethnic background may not fully resonate with the results of this current study. In fact, during the data analysis process, the female Asian American peer reviewer expressed her struggles in relating to Subcategory C-3, Have Vocational Conviction. Her personal experiences as a woman from a collectivistic family are different from many participants who are from a U.S. upbringing. Moreover, during the nomination process, excepting the African American key informant, no other African American nominees responded or participated in the nomination process. Another key informant of minority status declined to participate in the nomination process due to demanding work. Some other nominees might choose not to participate in the nomination process due to similar reasons. Also, for the disability groups, one deaf psychologist shared her difficulty to think of potential nominees in the deaf community especially with the limited geographic location for nominations. Additionally, the majority of participants identified in this study worked with upper-middle or upper class populations, their experiences might not be applicable for practitioners working with lower socioeconomic status populations. Further, as with any qualitative design, the result of the present study may have affected by the biases of researchers. Biases may include gender, sexual orientation, age, race, ethnicity, culture, socioeconomic status, religions, personal professional orientation and perceptions of the concept of resilience. These issues were described in detail in Chapter Three, Validity. Despite every effort was made to ensure trustworthiness and to increase the validity of this qualitative study, researchers' unconscious biases may have influenced the results. For example, even thought the primary researcher has previously conducted research on resilience and the

auditor has years of extensive experiences studying counselor development, resilience and burnout prevention, their passion for this research topic may also played a bias role in the study. Also, the primary researcher is a male international student from an Asian country. The lens he wore during the interviews and data analysis process might be different if this study was primary conducted by individuals from a different nationality. Thus, when interpreting or applying the results, limitations of this study should be considered.

Research Recommendations

A number of recommendations for future research on mental health professionals are suggested in this section.

1. The concept/characteristic of *connectedness* of resilient therapists is worth further exploration. The concept/characteristic of *connectedness* is a major finding of this present study. This concept/characteristic has not been acknowledged or accented in previous studies on therapist resilience, risk-factors, and protective-factors studies, and other related studies focusing on therapists' competence, proficiency, development and depletion. In the current study, *connectedness* was the main storyline that connected each category across the entire data analysis process. Future research would benefit by studying the role of *connectedness* in therapists' resilience development. Future research would also benefit by illuminating ways to establish, manage or advance therapists' competence of *connectedness*. In particular, further exploration of how *connectedness* interlinks with each aspect of therapists' lives (e.g., personal and professional relationships, core values and beliefs framework, the core self, and opportunities for continual development) would advance the field of research on resilient therapists.

2. Continue to advance or validate the definition of Highly Resilient Therapists. One major goal of the present study was to offer a definition that can more accurately define the term Highly Resilient Therapists. After the research, the major feedback was that a person cannot stay highly professionally resilient without having a fulfilling personal life. With an integration of the research participants' feedback and the research results, a definition of Highly Resilient Therapist was offered in this present study. Future research would benefit by continuing to advance a comprehensive definition of Highly Resilient Therapists.

3. Study spirituality/religion as a force/energy of highly resilient therapists. In the present study, nine out of 10 participants identified forces/energy that drive them to grow through personal and professional risks. Interestingly, four participants who identified with spirituality/religion were all able to identify forces/energy associated or influenced by their spiritual or religious beliefs. Their responses seemed to echo Richardson's (2002) idea that "there is a force within everyone that drives them to seek self-actualization, altruism, wisdom, and harmony with a spiritual source of strength. The Source is resilience (p. 313)." In recent years, the effects of spirituality and religion on mental health and well-being have received increasing attention in the field of psychology; therefore, future research would benefit by studying the role of spirituality and religion in therapists' experience of maintaining and developing resilience.

4. Study the concept of hope/optimism/positivity of highly resilient therapists. In the present study, the majority of research participants of the present study identified word/phrase characteristics that were associated with "hopefulness," "positivity," and "optimism." These word/phrase characteristics reinforced Werner's (1992) idea that, in

her classic longitudinal study, “hope” (p. 265) was the central component for resilient children to feel confident, to cope, and to succeed against the odds. Thus, future research can continue to contribute the research line of resilient therapists by investigating the concepts of hope, optimism, and positivity and how they interplay with therapists’ depletion and disruptions as well as resilience development.

5. Study highly resilient therapists who are from diverse backgrounds or working with diverse populations. With respect to diversity of participants’ racial/ethnic and cultural backgrounds, the sample of the present study consisted of nine Caucasians and one Native American. And, there is only one male therapist in the sample. Future research would benefit by expanding or implementing sample populations that are more represented in the profession, such as ethnic minorities and males. Research samples beyond Minnesota and the U.S. would also benefit the research line of therapist’s resilience. Furthermore, with respect to the client populations, the majority of the sample in the present study works with young adults and adults in private practice and community settings. Future research would benefit by studying resilient therapists who work in different workplace (e.g., hospitals, college counseling centers) or work with different client populations (e.g., children, aging adults), clients with special issues (e.g., victims of crimes, abused individuals, disability), or clients from low socioeconomic status groups.

6. Explore developmental stages of “resilient integration” of highly resilient therapists. All participants in this present study were able to identify a period of time or critical incidents that they experienced a sense of, or similar to, boredom, apathy, or even disruptions or depletion. During the interviews, participants all openly and genuinely

shared their vulnerability at that time as well as the turning points they bounced back and re-engaged again. These participants' experiences seemed to be relevant to the "resilient reintegration" stage of The Resiliency Model (Richardson et al., 1990) as well as the "currently experienced growth" in Orlinsky et al.'s (2005) study on psychotherapists' development. If risks, challenges, boredom, apathy, disruptions or depletion are somewhat inevitable in counselors' development, future research would benefit by exploring the "resilience integration stages" that highly resilient therapists go through in responding to adversities or critical incidents. A model of resilience integration stages of highly resilient therapists may not immune therapists from difficulties or adversities in their personal or professional lives; however, it might help therapists foresee, forearm, and know what to expect in order to bounce back and become even more resilient after challenges and hardships. Thus, future research can contribute greatly to the research line of resilient therapists by exploring resilience integration stages of highly resilient therapists.

7. Develop a psychological instrument specifically tailored to measure mental health professionals' resilience status. From a pathological perspective, a number of instruments were developed to assess mental health professionals' deficits and impairment, such as Maslach Burnout Inventory (MBI; Maslach, Jackson & Leiter, 1996), Secondary Traumatic Stress Scale (STSS; Bride et al., 2004), and Compassion Fatigue Self Test for Helpers (CFST; Figley, 1995). Quality of Life Scale Version 5 (ProQOL 5; Stamm, 2009) is the only validated instrument tailored for mental health professionals that assesses both positive aspects (compassion satisfaction) and negative aspects (secondary traumatic stress and burnout) of caring professionals who experience

suffering and trauma. However, concepts measured in ProQOL 5 and their associations with characteristics or qualities of resilience are uncertain. Another instrument, the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003), one instrument in the present study, was originally developed to measure and quantify resilience for the general population and to assess treatment responses for clinical populations. Although CD-RISC was supported by several published studies (Karairmak, 2010; Lamond et al., 2008; Connor & Zhang, 2006), it was not specifically designed to measure resilience of caring professionals. Thus, developing a validated instrument that is specifically tailored to assess resilience of caring practitioners will benefit the field of counseling and psychology as well as help expand the resilient therapist studies from a qualitative methodology to quantitative approaches.

8. Study similarities and differences between highly resilient therapist and master therapist studies. Findings of the present study shared a number of similarities with master therapist studies (e.g., love of learning, humility, self-acceptance). A qualitative meta-analysis study of highly resilient therapist and master therapist studies would benefit the field by investigating similar and different characteristics between these two types of therapists. With more understandings of the similarity and difference between these two lines of studies of high functioning therapists, recommendations could be made to training programs for refining suitable training goals based on the missions and purpose of training programs.

Training and Practice Implications

Many training programs may have been aware of and stressed the importance of therapists' burnout prevention and self-care strategies. However, what qualities or

characteristics therapists need to have or nurture in order to become resilient is no less important than knowing what to do to prevent burnout. The major purpose of this present study is to explore characteristics that one needs to "have" or "nurture" so that one can "be" or "become" a highly resilient therapist. Thus, recommendations in this section are made for academic and clinical training programs for nurturing future highly resilient therapists. In particular, recommendations made in this section have a focus on findings from this present study that are often less stressed in academic and clinical training programs.

Emphasize the characteristic of "connectedness" as a way to foster future highly resilient therapists. The concepts of "connectedness," "stay connected," and "connections" found in this present study are a call to training programs to pay attention to students and supervisees' sense of connectedness in both personal and professional aspects. Similar to plant a seed, through cultivating the sense of "connectedness," students and advisees would learn to acknowledge and build the practice into career-long benefits. In addition to the central characteristic of "connectedness," the present study yielded four categories, related subcategories and word/phrase characteristics. Following the flow as the findings of the present study, specific suggestions are made below.

1) Validate the significance of personal relationships. Strong interpersonal connections with family and friends are important characteristic of being a highly resilient therapist. To be a highly resilient therapist, one needs to feel loved and supported in personal relationships. For most participants, a loving and supportive partner or spouse is a strong support for maintaining a work/life balance rather than sacrificing one for another. Thus, when training future therapists, it is important to remind students and advisees to nurture

personal relationships as well as learn to practice a balanced life—personally and professionally.

2) Stay connected to professional support. Clinical supervisions are often mandated in training programs. However, after students and supervisees finish their formal training and/or obtain licenses, supervision is no longer required. According to the results of the present research, actively connecting with professional consultation partners or groups is an important characteristic for therapists to stay resilient. In other word, to remain resilient, one cannot stay isolated in this profession. With more opportunities to feel loved and supported by professional colleagues as well as remain a humble, open and vulnerable stance for constructive feedback, students and supervisees are more likely to nurture resilience.

3) Develop and strengthen a personal values and beliefs base. Students and supervisees would benefit from developing a personal value/belief base. Oftentimes, in a training program's core courses, such as ethics, counseling theories and practicum, students and supervisees' personal values and beliefs may be addressed; however, learning about ethical principles and guideline, and awareness of how trainees' personal values may influence their work with clients are often the major focus. Students and supervisees' development of personal values and beliefs that could help form their worldviews are less encouraged. Based on the findings of the present study, a profound perspective that is based on personal values, spirituality or religion is a crucial anchor that grounds highly resilient therapists to understand human suffering and injustice. Thus, in addition to being familiar with ethic codes and being aware of how personal values may influence the counseling work, students and supervisees would benefit from being encouraged to

develop or strengthen a strong base of personal values and beliefs as a way to prepare themselves to become resilient therapists.

4) Emphasize the importance of engaging with the core self. Training programs have a goal to train competent practitioners who provide great one-way care for others. Focus on self are often less stressed or seems selfish or less important. According to the results of this present study, students and supervisees would benefit from learning to actively and assertively engage with the core self. Oftentimes in training programs, students and supervisees may tend to highlight their strengths and "hide" their limitations or shortcomings. According to the findings of this present study, knowing and accepting one's personal limitation and shortcomings is as empowering as celebrating one's strength. Therefore, fostering a learning environment that accepts students' limitation and shortcomings as well as encourages students and supervisees to gain self-knowledge and accept their authentic self would significantly contribute to trainees' resilience development.

In addition, cultivating a mindset that one's professional resilience cannot be separated from having a fulfilling personal life is another key for nurturing highly resilient therapists. While preparing students and supervisees to provide great care for others, it is also important for training programs to empower students and supervisees to fiercely protect and conserve their core selves. Namely, since a fulfilling personal life cannot be separated from a resilient professional life, it is important for educators and supervisors to not only emphasize the importance of academic success, but also to teach and model assertiveness in creating a balanced and fulfilling personal life so as to foster a learning environment that nurtures highly resilient therapists.

5) Encourage and validate vocational conviction. Often, students and supervisees gain self-knowledge through practicum and internship. They also gain insight into their vocational affinities. According to the findings of the present study, students and supervisees would benefit from being encouraged to consistently examine the congruence between vocational aptitude, workplaces, work settings, client populations, and professional roles. More importantly, if students and supervisees were encouraged to fearlessly pursue vocational conviction that is consistent with personal aptitude, expertise, work settings, client populations, and professional roles, they are more likely to bounce back from professional risks, burnout, depletion, or disruptions and become a career-long highly resilient therapist.

6) Appreciate curiosity and love of learning. Highly resilient therapists do not stop learning. They do not stop intellectual and personal growth. On-going growth is a commitment in this profession. Although students and supervisees might feel that they have already learned a lot during their training, it is important to educate students and supervisees about the importance of being a life-long learner. In addition to staying curious about new knowledge or counseling approaches in their professional lives, students and supervisees would benefit from engaging in ongoing personal growth through continual understanding about inner self, vocational self and spiritual self.

Summary

Through a two-level sample screening procedure, 10 highly resilient therapists from diverse disciplines were recruited to participate in a qualitative study aiming to explore characteristics that sustain therapists' resilience. Participants were interviewed in person. Of the 10 participants, 9 were female and 1 was male; age ranged from 41 to 70

years old. Nine participants identified as White and 1 identified as Native American. Seven participants were doctoral-level licensed psychologists, 2 participants were master-level licensed marriage and family therapists, and 1 was a master-level licensed social worker. One practiced at a college counseling center, 5 were in private practice, 2 were in community clinics (outpatient/day treatment), and 1 practiced in both a community clinic (outpatient/day treatment) and a private practice. Data were analyzed using Grounded Theory (Strauss & Corbin, 1998) as the framework. The research findings yielded four categories, 11 subcategories, and related word/phrase characteristics. Four major categories are (A) Drawn to Strong Interpersonal Relationships, (B) Possess a Core Values and Beliefs Framework, (C) Actively Engage with the Core Self, and (D) Desire to Learn and Grow. A strong web of vibrant *connectedness* was identified as the central characteristic that interlinked with each category. A definition of Highly Resilient Therapists was proposed based on the results of the study.

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Appendix A

Invitation to Key Informants

Dear _____:

I am a doctoral candidate in the Counseling and Student Personnel Psychology Program at the University of Minnesota. I am conducting my dissertation research on the characteristics of highly resilient therapists. Thomas Skovholt, Ph.D., L.P. is my advisor. He is a former President of the American Board of Counseling Psychology, a current APA Fellow, and an active part-time practitioner. Our goal is to identify highly resilient therapists in Minnesota. Because of your expertise, experience, and reputation in the mental health professions, you have been identified as a key informant for our study.

Therefore, we would like to invite your assistance in nominating up to 3 therapists whom you believe exemplify the highly resilient therapist. In this study, we consider a highly resilient therapist based on the following criteria:

1) This person was trained in a mental health field at the graduate level
2) This person has been actively working with clients full or part time for a minimum of 10 years
3) This person can be described as a highly resilient therapist, which we define as follows:

> *"While working as a therapist over many years, a highly resilient therapist is effective as a therapist with their clients and is able to be fully engaged with client after client. Over time, a highly resilient therapist is able to continually bounce back from discouraging and disruptive aspects of clinical work. The highly resilient therapist is also able to develop recurrent professional optimism and vitality, as well as experience on-going professional growth."*

We appreciate very much if you would submit your nominees by responding to this email. It would be very helpful if you could provide each nominee's email address. For the privacy of your responses, nominees will not be informed of their nominators. They will only be told they have been nominated as a highly resilient therapist. Nominees who received the most nominations will be invited to complete a second-step of two short surveys. After the short surveys, potential participants will be invited to participate in a 60 minutes interview as part of our qualitative study.

Thank you for taking the time to nominate highly resilient therapists in Minnesota. Based on your expertise, experience, and reputation in the mental health professions, we believe that your efforts will make a difference and help us understand the characteristics that sustain, retain, and enhance therapists' resilience development.

If you have any questions, you may contact me at hou00001@umn.edu, or my advisor Dr. Thomas Skovholt at skovh001@umn.edu. Thank you so much for your time and consideration.

Sincerely,

Jian-Ming (J.M.) Hou, M.S.Ed.
& Thomas Skovholt, Ph.D., L.P.
Counseling and Student Personnel Psychology (CSPP)
Educational Psychology
University of Minnesota

Appendix B

Invitation to Nominees

Dear _____:

I am a doctoral candidate in Counseling and Student Personnel Psychology Program at the University of Minnesota. I am conducting my dissertation research on the characteristics of highly resilient therapist. Thomas Skovholt, Ph.D., L.P. is my advisor. He is a former President of the American Board of Counseling Psychology, a current APA Fellow, and an active part-time practitioner. Earlier this month, we began a peer nomination process in order to identify highly resilient therapists in Minnesota. Because of your expertise, experience, and reputation in the mental health professions, you have been nominated as a highly resilient therapist for our study.

Therefore, we would like to invite your assistance in nominating up to 3 other therapists whom you believe exemplify the highly resilient therapist. In this study, we consider a highly resilient therapist based on the following criteria:

1) This person was trained in a mental health field at the graduate level
2) This person has been actively working with clients full or part time for a minimum of 10 years
3) This person can be described as a highly resilient therapist, which we define as follows:

> *"While working as a therapist over many years, a highly resilient therapist is effective as a therapist with their clients and is able to be fully engaged with client after client. Over time, a highly resilient therapist is able to continually bounce back from discouraging and disruptive aspects of clinical work. The highly resilient therapist is also able to develop recurrent professional optimism and vitality, as well as experience on-going professional growth."*

We appreciate very much if you would submit your nominees by responding to this email. It would be very helpful if you could provide each nominee's email address. For the privacy of your responses, nominees will not be informed of their nominators. They will only be told they have been nominated as a highly resilient therapist. Nominees who received the most nominations will be invited to complete a second-step of two short surveys. After the short surveys, potential participants will be invited to participate in a 60 minutes interview as part of our qualitative study.

Thank you for taking the time to nominate highly resilient therapists in Minnesota. Based on your expertise, experience, and reputation in the mental health professions, we believe that your efforts will make a difference and help us understand the characteristics that sustain, retain, and enhance therapists' resilience development.

If you have any questions, you may contact me at hou00001@umn.edu, or my advisor Dr. Thomas Skovholt at skovh001@umn.edu. Thank you so much for your time and

consideration.

Sincerely,

Jian-Ming (J.M.) Hou, M.S.Ed.
& Thomas Skovholt, Ph.D., L.P.
Counseling and Student Personnel Psychology (CSPP)
Educational Psychology
University of Minnesota

Appendix C

Invitation to Potential Participants

Dear _____:

Recently, you and other therapists were invited to participate in our peer nomination process as a way to identify Highly Resilient Therapists in Minnesota. **You are one of the therapists who received nominations as a Highly Resilient therapist. Therefore, we would like to invite you to participate in the next step of our sample recruitment by completing a short online survey. This online survey will only take about 10 minutes to complete and can be accessed by the following link:** https://umn.qualtrics.com/SE/?SID=SV_56eZ0yGBHdd1SwR

Your responses of the online surveys will be used for sample recruitment purposes only. After completing the online survey, you will receive a confidential email giving you feedbacks about your results and normative data. Potential participants will be invited to participate in a 60 minutes in-depth interview as part of our qualitative study.

Thank you so much for your time and consideration in filling out the short online survey. Based on your expertise, experience, and reputation in the mental health field, we believe that your efforts will make a difference and help us understand the characteristics that sustain, retain, and enhance therapists' resilience development. If you have any questions, you may contact me at hou00001@umn.edu, or my advisor Dr. Thomas Skovholt at skovh001@umn.edu.

Sincerely,

Jian-Ming (J.M.) Hou, M.S.Ed.
& Thomas Skovholt, Ph.D., L.P.
Counseling and Student Personnel Psychology (CSPP)
Educational Psychology
University of Minnesota

Appendix D

Reports of Survey Results

Dear _____:

Thank you very much for filling out the online survey. We told you that we would give you feedback in consideration of your efforts.

The first 10 questions of the survey are from the Compassion Satisfaction Subscale of the Professional Quality of Life Scale Version 5 (Pro-QOL 5). The next 25 questions are from the Connor-Davidson Resilience Scale (CD-RISC).

The sum score of your Compassion Satisfaction subscale is _____, indicating that your level of Compassion Satisfaction is _____ (*42 or more=High; Between 23 and 41=Average; 22 or less=Low*).

The sum score of your CD-RISC is _____. You scored above one standard deviation *(SD)* of the general population mean (*M*=80.4; *SD*=12.8), indicating your resilience level is _____.

If you would like to know more about these two scales, you may go to the following websites:
(1) Pro-QOL 5: http://www.proqol.org/ProQol_Test.html
(2) CDRISC: http://www.connordavidson-resiliencescale.com

Thank you very much again for participating in the peer nomination process and filling out the online survey. Based on the purpose of the study and our goal of recruiting a diverse sample (e.g. practice settings, disciplines, racial/cultural backgrounds…etc.), we will begin to contact potential participants for a 60 minutes in-depth interview. If contacted, please consider joining us in exploring the characteristics that sustain, retain, and enhance therapists' resilience development.

Sincerely,

Jian-Ming (J.M.) Hou, M.S.Ed.
& Thomas Skovholt, Ph.D., L.P.
Counseling and Student Personnel Psychology (CSPP)
Educational Psychology
University of Minnesota

Appendix E

Interview Invitations

Dear _____:

As you may recall, I am conducting my dissertation research on the characteristics of highly resilient therapists. Thomas Skovholt, Ph.D., L.P., is my advisor. **We are writing to invite you to be one of the participants for our study exploring the characteristics of highly resilient therapists.**

Recently, in order to identify highly resilient therapists, we used a two level-sample screening procedure through (1) peer nomination, and (2) a short online survey (CD-RISC and Pro-QOL 5). **You are chosen to be our final list of research participants because you are one of the therapists who received the highest numbers of nominations as a highly resilient therapist, and you scored high on both scales.**

The last step of the study will be conducted through a 60 minutes interview by me, the primary researcher. The interview will be transcribed and analyzed using qualitative methods. I will send you a copy of the verbatim interview transcription and initial results of coding for your clarification and verification in order to ensure our study fully manifests your wisdom, insight, and knowledge. When the research is concluded, I will send you a copy of the completed five-chapter dissertation.

We hope that the in-person interview will take place in the next three weeks at your office or a mutual agreed location. If you agree to participate in the interview, please take 3 minutes to fill out a demographic questionnaire and indicate 3 preferred interview dates/times through the following link:
https://umn.qualtrics.com/SE/?SID=SV_bHNAfCwrr8yBK5f

Again, based on our two-level sample screening, we are convinced that you are an ideal exemplar of highly resilient therapists in Minnesota. We believe that your expertise and experience will make a difference and help our understanding of characteristics that sustain, retain, and enhance therapists' resilience development. Thank you for your consideration. If you have any questions, you may contact me at hou00001@umn.edu, or my advisor Dr. Thomas Skovholt at skovh001@umn.edu.

Sincerely,

Jian-Ming (J.M.) Hou, M.S.Ed.
& Thomas Skovholt, Ph.D., L.P.
Counseling and Student Personnel Psychology (CSPP)
Educational Psychology
University of Minnesota

Appendix F

Informed Consent Statement

You are invited to participate in an interview regarding characteristics of highly resilient therapists. This research is being conducted by Jian-Ming Hou, M.S. Ed. for his doctoral dissertation in the Counseling and Student Personnel Psychology Program (CSPP) at the University of Minnesota. He is advised by Dr. Thomas Skovholt at the University of Minnesota.

Background Information: Through interviews, this study will utilize qualitative methods to answer three major questions: (1) What are the characteristics of highly resilient therapists? (2) Is there an innate or inner force that drives highly resilient therapists to grow through professional risks? (3) How can one more accurately define the term "resilient therapist"? Your input will greatly help us enhance our understanding of highly resilient therapists.

Procedure: If you agree to this study, we will ask you to participate in a 60 minutes interview. The interview consists of 11 open-ended questions. The interview will be audio-recorded and transcribed.

Risk and Benefits of being in the Study: There are minimal risks and hopefully many benefits associated with this study. For example, each participant will be sent by attachment a copy of the completed five chapters dissertation when it is completed.

Confidentiality: The interview is confidential. The records of this study will be kept private. In the dissertation and any report we might publish, identifying information will be removed from the quotations from the interview.

Voluntary Nature of the Study: Your decision on whether or not to participate in this study will not affect your current or future relations with the University of Minnesota, or the investigators. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contact and Questions: If you have any questions, you may contact Jian-Ming Hou at hou00001@umn.edu or his advisor Dr. Thomas Skovholt at skovh001@umn.edu. If you have any questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may contact the Research Subjects' Advocate Line at the University of Minnesota, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; telephone (612) 625-1650.

Participant Certification: I have read the above information. I have had the opportunity to ask questions and have received answers. By completing the following demographic questionnaire, I agree to take part in the interview as a research participant in this study.

Appendix G

Demographic Form

Name of Participant: _____

Office Address: _____

Phone Number: (o) _____

1. □ Male □ Female □ Other (Please specify) _____
2. Please check your age?

   □ 21-30 years old □ 31-40 years old □ 41-50 years old □ 51-60 years old

   □ 61-70 years old □ >71 years old
3. Please indicate the racial/ethnic group you with which you most strongly identify:

   □ White □ Black/African American □ American Indian/Alaska Native

   □ Asian/Pacific Islander □ Hispanic/Latino

   □ Multiracial (Please specify) _____ □ Other (Please specify) _____
4. Do you have a religious preference? □ Yes (Please specify)_____ □ No
5. What is your highest level of education?

   □ M.A. / M.S. □ M.S.W. □ Ph. D. □ Psy.D. □ Ed.D.

   □ Other (Please specify) _____
6. Please specify your professional credentials:

   □ L.M.F.T. □ L.S.C.S.W □ L.C.S.W. □ L.M.H.C. □ L.P. □ L.P.C.

   □ Other (Please specify) _____
7. How many years of post-degree counseling/therapy experience do you have?

   □ < 2 years □ 3-5 years □ 6-10 years □ 11-15 years □ 15-20 years □ > 20 years
8. In what type of setting do you currently perform your practice?

   □ University Counseling Center □ Private Practice □ Community Clinic

   (Outpatient/Day Treatment) □ Inpatient/Hospital □ Other (Please specify) _____
9. Do you now work full time or part time? □Full time □Part time □ Other (Please specify)
10. On average now, how many hours do you directly work with clients per week?

    □ 0-10 hours □ 11-20 hours □ 21-30 hours □ 31-40 hours □ greater than 40 hours

---

Scheduling An Interview: Please list 3 possible day/time and suggest a location (i.e. your office) for scheduling a 60 minutes interview with you.

1. Date/Time (am/pm): _____
2. Date/Time (am/pm): _____
3. Date/Time (am/pm): _____

Meeting Location: _____

Comments:
_____

Thank you very much for participating in this study! We will contact you to confirm a time and location for an interview. I look forward to talking to you in person.

Appendix H

Semi-structured Interview Protocol

1. Reflect on your professional development. How have you remained determined, vibrant, and continued to grow as a therapist? Is there a core force, energy, or source that have driven and influenced your practice over the years? (Props)
2. In your professional life, (1) were there periods of time you experienced boredom, apathy, or even disruptions or depletion? If so, when and what were those experiences like? (2) What have been turning points for you to bounce back and engage again? What characteristics about you or characteristics you have developed have helped you become more resilient after that period of time? (Props)
3. What characteristics may have your professional colleagues notified so that you received multiple nominations? (Props)
4. Reflect on your professional career. (1) Are there critical incidents such as extremely difficult, demanding, unsuccessful cases, or the suffering of others that challenged your fundamental personal or professional beliefs? What were these experiences like? How did you deal with them? (2) What characteristics about yourself that you have recognized or characteristics you have developed have helped you become more resilient after that period of time? (Props)
5. Over the years of your practice, you might have experienced many other critical incidents in your professional life and shaped your understanding of human suffering and growth. What has grounded you as a therapist over these years and challenges? (Props)
6. Given two equally experienced therapists, what characteristics distinguish one who

grows more vibrant, energetic, and fully engages with client one after another, whereas the other experiences boredom, apathy, or even depletion? (Props)

7. In your definition, what are some essential characteristics (recipe/ingredients) for a therapist to maintain resilience in their professional work? (Props)
8. I asked this before, but let me ask it again. Is there a core force/energy/source for you to become a resilient therapist? If there is one in you, can you name it? (Props)
9. What might be a helpful metaphor you would use to describe a highly resilient therapist?
10. In our study, we define "highly resilient therapists" as: ***"While working as a therapist over many years, a highly resilient therapist is effective as a therapist with their clients and is able to be fully engaged with client after client. Over time, a highly resilient therapist is able to continually bounce back from discouraging and disruptive aspects of clinical work. The highly resilient therapist is also able to develop recurrent professional optimism and vitality, as well as experience on-going professional growth."*** In your opinion, is there any thing missing in this definition? How can we better define highly resilient therapists?
11. Is there anything that I did not ask that you think is important to know about you as a highly resilient therapist? (Props)

Appendix I

Summary of Categories, Subcategories, and Related Word/Phrase Characteristics

Category A. Drawn to Strong Interpersonal Relationships

Subcategory A-1: Strongly Connected to Personal Relationships

Subcategory A-2: Stay Connected to Valuable Professional Relationships

Subcategory A-3: Have Compassion for Others

Category B. Possess a Core Values and Beliefs Framework

Subcategory B-1: Have Theories/Theoretical Approaches as a Roadmap

Subcategory B-2: Have a Personal Values/Beliefs Base

Category C. Actively Engage with the Core Self

Subcategory C-1: Have Self-Knowledge

Subcategory C-2: Have Compassion for Self

Subcategory C-3: Have Vocational Conviction

Subcategory C-4: Fiercely Engage In Self-Conservation Mode

Category D. Desire to Learn and Grow

Subcategory D-1: Desire to Ongoing Intellectual Development

Subcategory D-2: Committed to Ongoing Personal Growth

Related word/phrase characteristics:

- *Feel Loved and Supported*
- *Humility/Openness/Vulnerability to Feedback*
- *Love/Kindness/Compassion*
- *Trust/Faith/Acceptance of Ambiguity/Patience*
- *Hopefulness/Positivity/Optimism*

- *Gratitude/Appreciation/Honor*
- *Self-Acceptance/Contentment*
- *Transparent With Clients*
- *Authenticity/Equality Between People*
- *Courage*
- *Boundaried Generosity*
- *Assertive in Creating a Balanced and Fulfilling Personal Life*
- *Humor*
- *Playfulness/Lightheartedness/Creativity*
- *Curiosity*
- *Commitment/Persistence/Determination/Dedication*
- *Intentional Self-Reflection/Self-Awareness*